

Digitized by the Internet Archive
in 2022 with funding from
University of Toronto

<https://archive.org/details/31761114671886>

CARON
XC12
S77



211

Government
Publications

S-49

S-49

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Tuesday 3 May 1994

Journal des débats (Hansard)

Mardi 3 mai 1994

Standing committee on
social development



Comité permanent des
affaires sociales

Subcommittee report

Rapport de sous-comité

Draft report
Dialysis treatment services

Rapport préliminaire
Services de traitement par dialyse

Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.

Hansard Reporting Service, Legislative Building,
Toronto, Ontario, M7A 1A2

Telephone 416-325-7400; fax 416-325-7430

Published by the Legislative Assembly of Ontario



Service du Journal des débats, Édifice du Parlement,
Toronto, Ontario, M7A 1A2

Téléphone, 416-325-7400 ; télécopieur, 416-325-7430

Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Tuesday 3 May 1994

Mardi 3 mai 1994

The committee met at 1541 in room 151.

SUBCOMMITTEE REPORT

The Chair (Mr Charles Beer): I draw the committee's attention to the report of the subcommittee on committee business, which you have before you. I'll read that into the record, and then there are a couple of changes which I'll explain, and if we get agreement on it, we can then proceed to deal with the dialysis report.

"Your subcommittee met on Monday 2 May 1994 to consider the method of proceeding on a matter designated pursuant to standing order 125 (children 'at risk') and other business referred to the committee, and has agreed to recommend:

"(1) That the committee schedule its meetings on the matter of children 'at risk' on the following dates: (public hearings) May 16, 17, 30, 31; (report writing) June 6, 7.

"(2) That the committee schedule its meeting on Bill 18, An Act to permit patients receiving Chronic Care to install their own Television or combined Television and Video-Cassette Recorder (Mr David Ramsay) on the following date: (public hearings and clause-by-clause consideration) May 10; and further, that the names of any witnesses to be invited to appear before the committee be determined by the subcommittee on committee business.

"(3) That the committee schedule its meetings on Bill 85, An Act to prevent unjust enrichment through the Proceeds of Crime (Mr Cam Jackson), on the following dates: (public hearings) June 13, 14, 20, 21; (clause-by-clause consideration) June 21; and further, that the names of any witnesses to be invited to appear before the committee be determined by the subcommittee on committee business.

"(4) That all other organizational matters relating to the above recommendations be determined by the subcommittee on committee business."

I would like to note three changes. First, the report-writing would be June 7; not 6 and 7, but June 7 only. And with respect to number 2, Bill 18, May 10 is now not possible for Mr Ramsay, so we would do that on Monday, June 6, if you could make that amendment.

Then there's a further recommendation, which I have discussed with Mr Wessinger, Mrs O'Neill and Mr Jackson. Next week, the Premier's Council on health is going to be presenting its report on children and youth to the Legislature, so we have discussed having them come to the committee, because we're not going to be sitting. We thought it would be very useful for them to make a presentation and for members of the committee to discuss the report with them.

The motion would read: "That the committee meet pursuant to standing order 108 to hear testimony from the Premier's Council on health on Monday, May 9, or Tuesday, May 10, depending on availability." I think it's going to be the Monday, but there's some question that it might be Tuesday, and that's why I've worded it that way.

If that report is acceptable with those amendments, I move the adoption of the subcommittee report. Is there any discussion?

Mrs Yvonne O'Neill (Ottawa-Rideau): Can we presume that we will have copies of the report presented to us at that time?

The Chair: Yes. In fact, we may have it at noon or 1 o'clock; I forget when it's being released. But we would certainly have copies when the committee is here.

Mr Jim Wilson (Simcoe West): Do we know at this point whether the minister will be making a statement in the House with respect to that report?

The Chair: My understanding is that it's the Premier's Council and the Premier would be presenting the report, and there will be an opportunity at that time for each of the opposition parties to respond. The council, I believe, is then going to have a press conference, and then at 3:30 or shortly thereafter we would start here.

All in favour? Thank you. The report is adopted.

DRAFT REPORT

DIALYSIS TREATMENT SERVICES

The Chair: We now move to the Dialysis Treatment in Ontario report. Just to make sure everybody's singing from the same hymnal, this is the one dated May 3, 1994. I remind members that because this is a draft, it is still a confidential document of the committee. Once it is approved, with or without amendments, it then becomes the report we table in the Legislature.

Before we get into the discussion of that report, I'll ask Bob Gardner, are there any points you want to make about the report as we have it now in front of us?

Dr Bob Gardner: The version of May 3 incorporates a number of changes that individual members have suggested over the last subcommittee meetings or have called me directly about. It also incorporates our copy-editing, quite a number of minor style and typo type of changes.

The only thing I would draw members' attention to is on page 35 of the latest version, a change in one of the proposed recommendations, number 6, about halfway down the page, the second-last line: "commitments to

funding dialysis and related treatment in the current fiscal year." We had "next fiscal year" in our discussions, but we do mean this year. It's a minor change, but because it's in a recommendation I do draw it to your attention.

All the other changes were of a clarifying and organizational nature.

The Chair: We've had an opportunity to discuss some elements of this, so perhaps the most useful way to proceed would be to ask the parliamentary assistant and the two critics in particular if they would like to comment, on the report or any other related element. We have two hours and 17 minutes to deal with this, but I don't think we need to use all that time if members are short, sharp, succinct, witty and pithy, all at the same time. That being said, perhaps the parliamentary assistant would like to be all of those things.

Mr Paul Wessinger (Simcoe Centre): You want me to lead off? I would have preferred to be the last speaker on this subject.

The Chair: I thought you would set the example.

Mr Wessinger: First of all, I'd like to compliment the researcher for the drafting of the report. I think he has captured the evidence that was presented here and has given a comprehensive report of that evidence and the many suggestions that were made with respect to the whole question of the treatment of chronic kidney failure disease. I'd like to make that as the first point.

The second point I'd like to make is the fact that all of us are probably in support of this report, which is something to be commended. I guess the evidence was such that it encouraged us all to the same conclusions with respect to the situation of dialysis treatment in Ontario. I'm going to highlight some of the elements of the report that I think are particularly relevant.

First of all, I think we have to recognize that the services for dialysis in the province are stressed. Notwithstanding the fact that the government has in the last few years expanded the facilities at a rate greater than the increased use, that has still not dealt with the problem of relieving the situation of the stress. We all recognize that the facilities are basically at capacity in the province and that there's a need to provide further services in this regard within the whole continuum of care.

1550

Second, the other element of the report that I think is very important is the recognition that we should be looking at more community-based services as the way of, first of all, meeting the need of those consumers of the service, and also as a means of providing more cost-effectiveness and dealing with some of the difficulties consumers have in accessing the service. We have to recognize that there are problems with respect to distance of travel, with respect to inconsistencies in the delivery of community care. A number of problems have been presented and are dealt with in the text of the report as well as in the recommendations.

The third point I'd like to make about the report is that it does recognize that we have to look at cost-effective solutions. We've been given a number of suggestions and recommendations which I think will need to be studied

with respect to more cost-effective ways of delivering the services. Some of these methods perhaps include the greater development of self-help satellites, of partially assisted centres, of providing the centres outside hospital settings, of providing home dialysis, and having a good mix and availability of the two types, both haemodialysis and peritoneal dialysis.

We also have to be aware that with the change in technologies that occurs in this field as well as all other medical fields, we have to develop a system that can take advantage of the changing technology to more effectively deliver service to the consumer according to the consumer's choice and with respect to cost considerations.

The fourth point is maybe the most important, the fact that there needs to be a comprehensive and continuing planning process with respect to the treatment of chronic kidney failure. This has to go beyond the aspect of providing dialysis treatment; it has to deal with the whole question of transplants as the preferred alternative, where that's a feasible medical alternative, and also look into the whole question of prevention.

It was clearly outlined by one of the witnesses that in perhaps 10 years we would see a decline in this disease as a result of the measures we could take on a preventive basis. Certainly that is the best solution to the situation, and if we look at the whole question of treatment and control of diabetes and treatment and control of high blood pressure, which are two of the major causes of kidney failure, we can see the opportunities for reducing the element of the disease in the community.

With that, I'll conclude. I'd like to compliment the members of the committee. I think we've worked well together in coming up with a report that will provide, hopefully, some original ideas and some good support for developing the long-term plan for the treatment of this disease.

Ms Jenny Carter (Peterborough): I think this is a very satisfactory report. It does seem to reflect the discussions we had and the information we received.

In my own riding of Peterborough, I have heard from several people who have problems with dialysis. It's very true that different people have different problems, so you can't just say, "There's a shortage in Peterborough and we should do this one thing, and that will solve all the problems." You have to have a range of answers in every area in order to meet the needs of the patients there. That need for flexibility and community-based solutions has been brought out in the report, so I'm pleased about that.

Of course a problem is going to be the expense of expansion, but I think we have looked at different ways of reducing the cost while at the same time expanding the service. It seems that sometimes a service that is more appropriate to a patient than, for example, being in a hospital and having haemodialysis can also be more cost-effective. We've mentioned the possibility of reusing equipment, bulk-buying it and so on. Hopefully, the overall cost of doing what we're asking will not be beyond the realm of what the ministry can afford.

I think the report is pretty good as it stands.

Mr Larry O'Connor (Durham-York): I appreciate

the opportunity to comment briefly on this report. Before we even got this report, we had some debate in the Legislature that brought about the need for this committee to sit. I thank Mr Wilson for actually bringing this forward as a section 125 so we could have this debate.

As we've gone through this debate, many of we committee members have had a chance to see and hear from a lot of people, for example MORE, the organization that is promoting organ transplants and availability. Recommendation 13 says that "the Ministry of Health explore means of increasing the numbers of kidney donations." When we talk about kidney transplants and the cost of dialysis, the cost of a donation and transplant is about the same as for a year's dialysis. Of course, the freedom then offered to that consumer who has that as a choice is a very meaningful way of improving someone's life circumstance.

Just as we were finishing these hearings, in fact, the son of a friend of my wife's, with whom she does a little bit of folk art, was going around with a beeper, on the waiting list for a kidney transplant. The unfortunate reality is that her son, who was 29 years old, expired on the table during the operation. Any time anyone goes through a medical procedure like a transplant, we can think of all the success stories out there, but there are still those who don't make it. We need to pause and think about that. When we reflect on the reality of the report and the whole issue, it goes beyond just some paper. It goes right down to touch people's lives. For this family from Oakwood who lost their son, it does have a different meaning and a different reality. I just wanted to share that moment with my colleagues here, because that's a reality that some people do have to face.

As the Central East Regional Dialysis Committee embarks on its work and as the working group on renal services gets together, I know they'll take a look at the work that's been compiled by this committee. I'm sure it will be a valuable tool for them, because we've had an opportunity to pull together some key people as we develop this report. I think they'll take a look at this and appreciate the effort we have made to this point.

I just want to congratulate and compliment Mr Gardner on his work in pulling together this report. It pulls together some of the recommendations that we all had shared, and I think the report itself has been pulled together for members of this Legislature in just about as non-partisan a way as possible, which doesn't happen too often but in the committee process it does happen a little bit more often. I appreciate my opposition members and critics for Health for the sound advice they're sharing with us and look forward to seeing some of the implementation take place.

1600

Mr Ron Eddy (Brant-Haldimand): I appreciate the report and compliment the writer, of course, and am particularly pleased with the recommendations that are set out in the report: very, very important. I notice number 7 in particular, "The ministry...act immediately to expand treatment services to ensure adequate and equitable access to dialysis treatment," so very important. I have great hopes for the transplant system and that donations will

increase. I hope we have a campaign to bring that to everyone's attention.

But the "adequate and equitable access" is so important in the rural areas where there are great distances to travel to a dialysis treatment centre, realizing that in rural areas it means someone stopping in very busy seasons to transport someone else for needed dialysis treatment. It's so very important to have it community-based and as close as possible. I'm particularly interested in the home self-treatment. I think we really must concentrate on that. I appreciate those recommendations.

The Chair: I wonder, with committee members' indulgence, recognizing that this hearing is being televised, if perhaps I might, for those watching, read the proposed recommendations.

Mr O'Connor: I think we support that, Mr Chair.

The Chair: The summary of recommendations then: "To summarize, the committee has recommended that:

"(1) The Ministry of Health respond to the standing committee on social development within 30 days on how it will ensure that adequate coordination takes place between the Central East Regional Dialysis Committee and the working group on renal services.

"(2) The government take into account the resources and capacities of district health councils to conduct complex strategic planning before assigning new projects to them.

"(3) The Ministry of Health explore other planning models for particularly urgent and complex issues.

"(4) The Ministry of Health develop mechanisms for disease-specific and needs-based planning. The officials and branches responsible for this planning must be clearly identified to legislators and the public.

"(5) The Ministry of Health, in consultation with the Kidney Foundation, specialists and other stakeholders, develop a kidney patient registry in Ontario.

"(6) The Ministry of Health report to the committee within 30 days on its commitments to funding dialysis and related treatment in the current fiscal year.

"(7) The Ministry of Health act immediately to expand treatment services to ensure adequate and equitable access to dialysis treatment.

"(8) In its immediate expansion of dialysis treatment, the Ministry of Health should prioritize community-based delivery and innovative projects.

"(9) Recognizing that dialysis is a medically required service as defined under the Canada Health Act, the Ministry of Health must ensure that home haemodialysis patients have equitable access to nursing and other services without user fees.

"(10) The Ministry of Health must ensure that it has committed sufficient resources to be able to respond quickly and comprehensively to the reports of the Central East Regional Dialysis Committee and the working group on renal services.

"(11) The Ministry of Health fund and encourage a broad spectrum of community-based facilities and services, from satellite centres, clinics under the Independent Health Facilities Act, to home care. It will need to

ensure that funding mechanisms are sufficiently flexible to encourage innovative community-based approaches.

"(12) The Ministry of Health explore innovative means of providing dialysis and related care in the most cost-effective, environmentally responsible and efficient way.

"(13) The Ministry of Health explore means of increasing the numbers of kidney donations.

"(14) The Ministry of Health integrate long-term policies to prevent chronic kidney disease into its overall health promotion goals and practices.

"Finally, we think a comprehensive and integrated approach is needed to solve the current problems of access to kidney treatment and to develop equitable and effective long-term solutions. Our recommendations have called for many specific changes, for systematic and continuous strategic planning, and for the development of a full continuum of treatment services for those with kidney disease. We think these recommendations should be seen as an integrated and comprehensive package. We hope that the ministry will respond in an equally comprehensive fashion. Our last recommendation is that:

"(15) Under standing order 37(d), the standing committee on social development is calling on the Minister of Health to respond to this report in a comprehensive fashion within 120 days."

We will have to move a motion to that effect at the end of our discussion but that just provides the recommendations so people will have a sense both of what we have been talking about and what we are talking about.

Mrs O'Neill: I'm glad you read the recommendations, Mr Chairman. I do think it's very important that we emphasize that we do expect a response from the minister, on some of these things sooner and some of them within a three-month time frame.

I was struck in the presentations mostly by those who use the service and the kinds of limitations that are made on the rest of their lives because they happen to have chronic kidney failure.

I was also struck by the fact that a professional in a centre often can change lives just with their drive, with their knowledge, with their ability to use resources effectively, and I think we saw that. There were times when the professionals who work in this field came before us and really were asking us to catch up to them. I think it was very important that we have those good role models.

I think the call for more research in this area is just mandatory for us as legislators to consider. I also think it is important that we realize that many people who are dealing with this who happen to be professionals are in more isolated areas. We certainly had excellent representation from the north. I think we were trying to help physicians, who often are the first contact or touchstone that people come to with their illness; that in those situations where there is a distance problem, physicians could be educated even through teleconferencing, that there could be consensus conferences. I think we should really encourage that kind of networking.

There was an emphasis on prevention by many presenters, particularly by the professionals and I think we all

feel that. That's why we have to spend money in public education on health issues. I don't think we can ever forget, however, that some people know almost from the day they're born that they're going to have this kind of illness hanging over their heads. There is quite a history of congenital passage of this disease.

All of that said, I think prevention should be an area that we put quite a few funds into.

I am still feeling incomplete about the organ transplant work. I think the report reflects as much as it could of what we heard, but I think we all presume that it goes on much more than it does and that it's much simpler than it is. If anything, I was struck by the complexities of that and really the sensitivity of the people who deal with that, that there are ways of getting a very informed consent, and sometimes a very consoling consent presented.

We as legislators have to keep an eye on the presumed-consent legislation that will now be studied by people in this area, because I really do think that most of us, as do many of the patients, feel that organ transplant is certainly one of the first and ideal choices for most patients.

Those are my thoughts. I'm very happy with the report. I feel that it sometimes is very helpful for a group such as ourselves to sit down and focus for a number of days on an issue that is of great concern to many people in Ontario.

1610

Mr Jim Wilson: I want to begin my remarks by thanking the committee members from all parties for taking the time and having the patience that was shown, and the understanding, in dealing with the resolution I put forward.

As members know, this resolution stems from many months—in fact, well over a year—of work on my behalf and that of my staff and other people in trying to come to grips with the dialysis crisis in the province.

I think it's somewhat unfortunate that it has taken an opposition member using every legislative tool that I can think of. There have been hundreds of petitions from the Simcoe county and New Tecumseth and Collingwood areas presented in the Legislature that have been signed by the good people of those area and that I've presented in the Legislature.

On December 9, the Legislature debated a private member's resolution standing in my name to once again try and convince the government that a community-based solution, a commonsense solution, is needed to the dialysis crisis, and of course there is this resolution before this committee.

While all of that sounds a little too—too many I's perhaps in those sentences and a little bit self-centred. I was struck at the very beginning when dialysis patients in my riding came to see me. In fact, they were too sick to come to see me. I went originally to Mr Alvin Hiltz's house in Collingwood and walked into his living room and saw a person—sorry. Mr Alvin Hiltz is in Alliston. Mr Robert Udall in Collingwood was the first patient I visited. I walked into the man's living room and couldn't

believe that in the 1990s there would be someone who didn't look very well and didn't look like he would probably survive the next couple of trips to Toronto that would have to endure to receive what is both a life-sustaining and medically necessary treatment such as dialysis.

I was struck that when we debated this thing on December 9 in the House, other members didn't have similar stories. I think the benefit of the hearings we've had is that a number of individuals came and all members have now brought forward stories from their ridings of people who are suffering with end-stage renal disease and require dialysis treatment.

It's a quality-of-life issue, and I think if we've learned anything during this process and the hearings, it's that while the government claims that everybody who needs dialysis treatment is getting some form of treatment, there's more to the issue than that. It's a quality-of-life issue when you have someone like Mr Alvin Hiltz, who spends 12 hours three times a week going to and from Toronto and in Toronto receiving haemodialysis—to hear his story and to have had the unusual and heart-wrenching experience of having Mr Hiltz appear at a public meeting in Alliston to tell us that he wasn't going to go to Toronto any more for his treatments and essentially telling a public meeting of over 200 people that he was giving up and committing a form of suicide.

Perhaps I could share with members that these hearings have helped lift, I think, the spirits of dialysis patients. Certainly, the individuals in my riding feel better; their morale is up. But we've also raised expectations. The reason I'm grateful for this report and appreciate the time lines that are in it is that I think it will—I hope it will—spur the government into action.

I found it very frustrating, and I think one of the most disturbing presentations was made by the chair of the Central East Regional Dialysis Committee. I found it a very apologetic type of presentation. In fact, Ms Linton seemed to be appearing before this committee to give us heck for investigating this matter, rather than explaining to this committee why it would take so long for district health councils to get this central east dialysis study under way.

I wanted to say that for the record, because I was very polite to Ms Linton, the chair of that central east study, when she was here, but I haven't been able to rest with my conscience since then because I really felt there were some more things that could have been done by district health councils to get the study, which was launched for the umpteenth time last year and was supposed to be finished by now, moving.

The recommendations in this report and the committee's report call upon the government to not necessarily wait for the end of the central east study, but to start putting actions forward now that would address the immediate crisis we have in the province.

I was struck too by the fact that the question of user fees came up in an indirect way at these hearings, and also rationing. It strikes me that politicians for far too long had denied the existence of user fees in our health care system. We've had politicians for years running

around saying that we don't have rationing and that we don't have two-tier medicine. I call them the three mythologies of health care.

We do have user fees for someone like Mrs Anne Archibald, whose daughter Jackie Archibald appeared before this committee on behalf of the Archibald family. She told us about the struggle her mother had in being hospitalized in Toronto, and that the only way to get out of the hospital was to convince the hospital to send her home with a dialysis machine, only to find out after the fact that the Archibald family in Beeton would have to come up with \$350 to \$400 a week to pay for the nurse.

I note that one of the recommendations of this committee deals with that in a very specific way. It calls upon the government to provide funding for medically necessary service and to recognize the whole spectrum of dialysis services as medically necessary services under the Canada Health Act, and therefore there should be no user fees. Certainly, John Archibald, Anne's husband, has told me many times that it is a lie to say there are no user fees currently in our health care system, because he's experiencing it to the tune of \$350 to \$400 a week on a very personal basis.

A couple of the things with rationing: I don't think we really were able to conclusively determine that rationing existed. The evidence presented to the committee was that in the United States, for a similar population, there were more dialysis patients or more people receiving some form of dialysis treatment and that therefore, with fewer dialysis patients recognized in Ontario, there must be some people out there who have a degree of kidney failure and are not being referred for dialysis services.

That's something on which I'm inconclusive in my own mind, as to the extent of rationing that might be going on. I hope it isn't going on. There was some anecdotal evidence presented to the committee, but I think the expectation is there on behalf of citizens that our health care system is there when you need it and that rationing should not be part of the system, although I will tell members, as they know, that physicians and health care workers have always practised some form of rationing. There aren't unlimited services. We know that when it comes to cancer and other types of services that are required, we have waiting lists in this province.

I think it's a question overall of setting priorities in the health care system and setting priorities for government. Today, members will know that Mike Harris, leader of the Ontario PC Party, launched our campaign to save medicare. It's contained in the document we released today called the Common Sense Revolution. We outline that health care is the number one priority of a Mike Harris government and we challenge other governments-in-waiting or the current government to make health care a priority.

While we identify a number of non-priority areas in government that we think should be cut and need to be cut if we're to get our deficit under control and if we're to bring down taxes in the province, health care will be wholly preserved and it will be fully funded, should we form the next government.

I'll tell you, the work of this committee and the work

surrounding dialysis that I have done and others have done in my party helped to convince my caucus colleagues that health care is in trouble in this province and that it must be protected at all costs. That won't mean that within the envelope of funding that's provided for the Ministry of Health we won't be continuing to look for savings and to deliver those services in the most efficient way possible.

I put that challenge out to other parties. It's nice to complain about things but it's another thing to list what your priorities are and what your non-priorities are and be prepared to take those hits from interest groups that disagree with perhaps your priority-setting and your non-priority-setting.

Just specifically to the recommendations, I wanted to perhaps point out that we may want to clarify recommendation number 3, that the Ministry of Health explore other planning models for particularly urgent and complex issues. My idea of a good report—and I do want to thank Dr Bob Gardner and the legislative research people for putting together an excellent report. However, recommendation 3, perhaps we could just explain what we mean by “other planning models.” Even in the context where the recommendation is contained in the report—I'm reading from the summary right now, it's not quite clear what we mean by that and perhaps we could just sharpen that point a bit, if there were more specific thoughts that members had on recommendation 3.

Also, recommendation 13, that the Ministry of Health explore means of increasing the numbers of kidney donations, I was wondering—perhaps other members may want to respond to this suggestion—since in a number of other areas we've asked the government within 30 days or 120 days to get back to this committee about its specific plans and actions, could we not in recommendation 13 also ask the government to come back and present a plan of action to this committee on how the government is to proceed to increase the number of kidney donations? I think that I'd be prepared to entertain a longer time frame than 30 days, but that it's incumbent upon the government to not leave that issue as a non-priority item but to come back to us on a priority basis and to let committee members know how the government plans to increase the number of kidney donations.

I also want to thank members of the kidney foundation who appeared before the committee and have been monitoring the committee hearings. Their input has been invaluable and I hope that the recommendation that calls upon the government to ensure that there's coordination between the central-east regional dialysis study and the working group on renal services by the kidney foundation—that we have helped in some way to make sure the coordination takes place between those two studies.

My preference, to state for the record because we've stated it in camera on several occasions, would have been that the government not have asked the district health councils to do the central-east regional study but instead the government should have first and foremost looked to the ongoing work of the working group on renal services under the auspices of the kidney foundation, that we should have looked there first before setting up a new

mechanism of study, that we should have taken and encouraged and supported the work of the kidney foundation, taken its ideas, and then presented a more concise mandate to the district health councils to implement the recommendations of the working group on a regional basis.

It strikes me that what the government did on a couple of occasions was announce that the central-east district health councils would get together and create a study. They left those district health councils in limbo for several months and didn't indicate what the terms of reference would be for that study. It's my understanding, and we had testimony here, that one of the major problems and one of the reasons the study's taking so long is and was that they couldn't come up with the terms of reference and couldn't get all the politically correct members together to do the study.

My preference would have been giving the district health councils a mandate to implement specific recommendations, rather than the way the government went about it.

I'll just conclude by once again thanking people for their participation. I am sincere about thanking all members. It's not that often that we agree on recommendations. The government itself in this case needs to be thanked in terms of the time frames that it has agreed to in the recommendations. I hope the government won't miss those time lines and that this committee has the authority to somehow pressure the government, should it miss a time line, to respond to the recommendations.

Finally, I want to thank my own constituents, Mrs Colleen Roth, who appeared on behalf of Mr Alvin Hiltz; Jackie Archibald, whom I mentioned earlier; and Mrs Isabelle Bates, who appeared on behalf of the south Simcoe chapter, Kidney Foundation. They've done a lot of work in the local area.

There's a great deal of community interest and community support, and my communities of Collingwood, Alliston and New Tecumseth are quite willing and ready and able to raise the capital dollars. In fact, I've run out of things to say to local service clubs that want to raise the capital dollars to set up a dialysis satellite. It's one of the questions that didn't get answered that I still face when I'm at home, “Why do we still have three machines in Alliston serving only three people, when there are several other dialysis patients in the area who could use those machines and share them?” It's a question that this committee hasn't answered. I think I learned that there's a more complex answer and that the answer isn't all that simple.

We'll be looking to the studies that are under way to come up with the most cost-effective way of providing dialysis services, hopefully on a community-based model. I have the same situation in Collingwood, where there are three machines in the area serving only three patients and the rest of them have to drive to either Toronto or Orillia. It's unfair. As I've said, it's a quality-of-life issue. I hope the government gets back to us in a very timely fashion with some specific actions that it's willing to take.

I want to thank you, Mr Chairman, for composing and sending the letter on behalf of the committee which asks

the Minister of Health, Ruth Grier, to review and respond to this committee with respect to the individual concerns, like Mr Hiltz, like Mrs Archibald and other dialysis patients who came forward. I'll be looking forward to the Ministry of Health's response with respect to those individual cases. I think that should be the top priority. I think the ministry should do that in a number of days, not months, because people are hurting out there and it's difficult to believe in this day and age that government has failed to provide the type of quality-of-life services that people expect and indeed deserve under medicare.

The Chair: Just before turning to Ms Sullivan for her final comments, members of the committee, I will be coming back to the letter you have in front of you just so we can approve that, and there are a couple of recommendations regarding the disposal of the report that I'll have to put before the committee. We'll do that upon completion of Ms Sullivan's comments.

Mrs Barbara Sullivan (Halton Centre): As I start my comments to the committee with respect to the report that's been drafted, I want to first of all indicate that I was very pleased to see Mr Wilson's initiative in bringing this matter forward. The question has been one that has been on the table for several years and it was difficult to know whether there was a crisis at the current time that was limited to one area of the province or that was more broadly based across the province. Certainly, we knew, and it's been very clear for a long time, that the lack of future planning was a serious gap in the system and led to some of the very precise scenarios that we saw. So for that, I do want to say that I think Jim Wilson has served the members of this committee and his constituents well, and I hope that the results of this report will move the issue along in terms of the attention paid to it by the Minister of Health.

1630

The second thing is, I know that the other members who have spoken have indicated their gratitude to witnesses who appeared before the committee. Both patients, people who are in actual treatment, and those who are involved in support services for patients and their families provided us with the benefits of their education, of their expertise and of their experience. Their participation, when in fact there is no major resolution to this issue by this committee other than recommendations going forward, I think was very useful to us and, frankly, will assist us in ensuring that there is action.

Our caucus has discussed the issues, the summary of recommendations, which have been so ably put forward by the legislative research, Dr Gardner, and we also want to congratulate Dr Bob for, in what is a very clear way, making the recommendations that came from each of us in the discussion that was on the table sound not only reasonable but articulate. I think there's no question that all of us who participated in this discussion concur with the recommendations that are included.

You will recall that as we were coming to some discussion with respect to the recommendations I was a little more adamant on some points than some of the other members were, and the recommendations therefore reflect a consensus rather than some of the stronger

positions that I would have liked to have put in some areas.

As a consequence, members of our caucus who participated in the hearings with respect to dialysis treatment in Ontario and in the drafting of the report, who concur in its findings, also want to submit a minority report which perhaps addresses some of the issues in somewhat stronger language. If I may, I would like to read that minority report to you. It will be attached to the document. It underlines, I think, with some greater urgency the very urgency that the entire committee saw, but where there was consensus on those issues we certainly wanted to underline some of those areas. The minority report is as follows:

"We were shocked to hear the Minister of Health tell the committee that current measures mean 'we are actually staying ahead of growth in patient numbers,' a statement that every analysis of current data shows is incorrect. In fact, Ontario is at present staying barely even with the need for new dialysis services, and in some parts of the province has already fallen behind. Whether the minister wants to admit it or not, we have a crisis in the availability of services that must be dealt with on an urgent basis.

"The minister cannot afford to wait for longer-term reports, and must immediately

"(a) set up a 'crisis committee' that will specify an interim implementation and action plan to ensure that those who are appropriate candidates for dialysis will have access to dialysis services, and determine funding requirements to meet immediate, short-term crisis needs, and

"(b) commit funding to ensure that those needs are met in the most appropriate manner.

"In the absence of doing so, the minister has no alternative but to establish guidelines and make these known to the medical profession and to the public on the basis on which dialysis will be made available to Ontario citizens, and whether these services will be restricted by age, by geographic area, by multiple symptoms, or other criteria.

"Over the longer term, we are convinced that the minister must establish a permanent central 'network' of major stakeholders, including professionals, facilities and consumers, to coordinate a provincial strategy and set standards for the entire spectrum of dialysis and transplantation services, including early diagnosis, treatment, rehabilitation and support services. Second-tier regional networks should implement that plan according to regional needs. Life support funding must be predictable, based on a multi-year approach to ensure stability, and take into account growth in end-stage renal disease; incentives must be provided to ensure the most effective and cost-efficient care, including training, modified forms of self-care, and the appropriate regional delivery of services. Major steps must be taken to encourage an increase in kidney transplantation, including necessary changes in incentives to hospitals, education of the public, and provincial law. Further, the serious fragmentation of divisions of the Ministry of Health in dealing with kidney disease must be addressed on an urgent basis.

"The district health council process is not appropriate for such specialized planning, which extends beyond a regional base, and which requires sophisticated needs-based analysis, disease prevention mechanisms, intense patient involvement and outcomes measurement. We recommend the increased participation of the academic health science centres in coordinating and implementing such a strategy."

As you will see—and I will pass this minority report around and will make a formal indication that our caucus would like it appended to the main report—the minority report that we're presenting simply underlines what we see as the urgency and the need for planning.

There are a couple of areas that I want to speak to directly, and one of them is with respect to comments about the fragmentation of divisions of the Ministry of Health in dealing with kidney disease. We have seen on more than one occasion the fragmentation within the Ministry of Health whereby one division is responsible for drugs, another division is responsible for institutional care, another division is responsible for health promotion and so on, and never the twain link. I think it was quite clear in the last round of drug benefit plan delistings of products, when some of the nutritional products were delisted from the ODB formulary, that there was a severe and immediate impact on kidney patients who require, by example, calcium carbonate to assist them in their treatment program. Furthermore, the threat of the delisting, while it's very difficult to measure how serious the threat was, of some other drugs used to ensure that a transplant is effective certainly created enormous concern among patients, among providers and among support organizations whose time and efforts had to be spent in battling what was a threat of the removal from the ODB of an absolutely vital medication, a medication that was itself lifesaving.

In speaking specifically to the issue of fragmentation, I think we're underlining the coordinated network approach that has to be taken, where the Ministry of Health has to come to the table with an integrated stance, understanding the full life cycle of the disease and the continuum of care associated with that disease. Professionals, whether they are delivering services in the home or in institutions, also must be a part of that network. In the facilities themselves, whether they're independent health facilities, hospitals or other centres—satellite centres, by example—patients themselves must be involved in the dialogue. That's why we are underlining a specific network.

Our minority report is an addendum, as we see it, to the main report. We would like it attached. We understand, if there cannot be consensus of all the parties to some of the stronger language and more direct discussion. We want to underline that we also concur and support the recommendations that have been put forward by the entire committee.

1640

The Chair: There are several other members who wish to comment. Just to be clear, under subsection 130(c) there may be a minority report, but am I correct, Mrs Sullivan, that you're saying that if members agree

with what you have added here, it would be agreeable to you to have that included as part of the report, if that were acceptable to all members? And if it is not, it's not a question of the committee agreeing or not: Any member may add a dissenting opinion.

Mrs Sullivan: I would certainly be appreciative if all members of the committee could support the minority report. If they can't, and my suspicion is that they will not be able to because of positions that were placed earlier in our discussions, we would still like to append it to ensure that there is an additional underlining of what we see as the urgency of next steps that must be taken.

Mr Wessenger: First of all, with respect to the minority appended report, the first concept I would take issue with is the whole question of the role of the DHC in the planning process. The district health councils are the vehicle, in my opinion, for determining the appropriate community needs and the appropriate community response to those needs, and I suggest that the recommendations put forward by the minority report would go contrary to that concept. We already have a vehicle established for planning on a community basis, which is the district health councils, and I would not want to see any weakening of that model.

With respect to the other recommendations, I would suggest that the statement that we're staying ahead of growth in patient numbers isn't an accurate statement for the period to which it relates, but I have indicated quite clearly on the record that we are in a situation of stressed facilities, we do face an increased growth in the future, and we have to deal with that situation. I think the report puts forward a strong position with respect to dealing with that issue.

In respect to Mr Wilson's comments concerning some of the recommendations, I would suggest that this committee's trying to determine which other appropriate planning models would at this stage not be very productive without a great deal of discussion and examination of what prospective planning models we could even look at to try to determine what might be the most appropriate. I would suggest it would not be productive in the time frame we're dealing with.

With respect to the question of exploring the means of increasing the numbers of kidney donations, there's no question that the ministry has been trying to increase the number of kidney donations. The position they have taken is basically the position put forward by Dr Stiller: to look at the institutional barriers with respect to the question of transplants and try to break down those institutional barriers. I know that's the position MORE has taken with respect to trying to encourage transplants, to try to deal with those barriers that exist within the institutions. The evidence given is that that is probably the aspect that discourages most the whole question of increased donors, that those barriers exist within our institutions.

That certainly is something that would bear fruit, looking at ways of how they're dealing with those institutional barriers. I know they're being looked at, I know they're trying to address that problem, and it will be interesting when we get the response within 120 days.

I'm sure the ministry will indicate the ways in which it's trying to break down those institutional barriers.

The other two questions, of presumed consent and mandatory choice, are ones which I think have to be dealt with on a broad consultation basis before any recommendations could be made by any committee. That is something that requires a lot of public input and consultation.

I'd remind Mr Wilson that when he said he wants a response, we will have the suggested recommendation "that the Minister of Health respond to this report in a comprehensive fashion within 120 days." I think that covers his concerns.

Mr O'Connor: Further on some of the conversation we've had since the last time I had the floor, one thing that was pointed out by my friend Mr Wilson is that he doesn't understand why central-east had to set up this committee to take a look at it. Then my friend Mrs Sullivan suggested that there be a crisis committee set up. I'm reluctant to say we should be setting up one more committee, and I think that's what Mr Wilson said even from the beginning.

But we've heard through the committee hearings and further that the working group on renal services won't be able to report till the fall, with a final report towards the end of the year, and that the work that's going to be done right now by the Central East Regional Dialysis Committee will take a look at those immediate problems, and those are just some of the problems Mr Wilson's pointed out.

I can't see where setting up a crisis committee to take a look at it is warranted. I guess that's where we get into the partisan part of the committee process, that you're not doing enough. But setting up committees? Mr Wilson, whom I'll loosely quote, and he'll correct me later, has said that what we don't need is more committees. I've got a problem with that, and I guess that's why we have this being brought forward as a minority report by the Liberal caucus.

Mr Jim Wilson: I want to begin by saying that I agree with the comments made by Mr Wessinger and Mr O'Connor and thank them for the comments with respect to the Liberal caucus minority report.

While I appreciate that the Liberal members are putting some thought into the issue, I just can't emphasize enough that setting up three more committees is bloody ridiculous and disgraceful. This minority report says one committee is a crisis committee, the second is a network, the third is a second-tier regional network. That's in addition to the two committees we already have. What I take from this report is that the Liberal caucus would like us to go back to our constituents and say, "Yes, we had a successful round of public hearings and recommendations, and we've set up three more committees on top of the two that are already going."

I agree with Mr O'Connor. It's been my consistent thought from the beginning that we should encourage what's already happening, given that it is happening; send resources on an urgent basis to the Kidney Foundation so it can get its work done; encourage the district health councils. Don't allow the chair or anyone else to come

back to anyone and, in an apologetic manner, suggest that there are all kinds of reasons why the central east study isn't done. Get it done.

We don't need another three layers of committees. I would seriously ask Mrs Sullivan to reconsider the minority report. While the language of it is wonderful and flowery and sounds very concerned, I think anyone who actually reads through it would be extremely disappointed in the Liberal caucus's response. They've missed the boat. The intent of the December 9 resolution and the intent of these committee hearings was to get solutions. People are tired of committees and they're tired of studies. They want solutions. People are hurting out there and they need solutions right away. It's incumbent upon us to find those solutions or, if we don't have them, to encourage the experts to come up with them.

The recommendations that have been agreed to by all parties aim towards that: asking the experts, as quickly as possible, to come up with the solutions, and calling upon the government to now set aside the financial resources and have the will to implement those solutions just as soon as they come off the press from the two committees that are already going. I think that's been the success of these committee hearings, and I would not want to see a minority report water down what has been accomplished today.

1650

Mrs Sullivan: I want to speak to some of the comments of the members from the New Democratic and Conservative parties who were commenting on this minority report.

The first issue, with respect to the time lines, is one that has to be addressed, and also the work that's already under way.

The time line situation is thus: The Kidney Foundation report is due in some months. It will be a substantially different kind of report than will be prepared by the central east committee. That committee, as we know, was requested to commence its work last October by the minister. We know the first meeting it held was in April. We do not believe, and I am certainly not convinced, that the recommendations from that committee will be available in a timely way to meet urgent, immediate needs.

As a consequence, the suggestion that a crisis committee be set up now to deal with the needs of the exact scenarios and situations that were brought to our attention has to be done. If it's a matter of an interim strategy, if that's what you prefer to call it, that is what we are calling for, indeed demanding. The situation in many areas, particularly in the central east area—however, also extending into Hamilton and into Ottawa and two or three other regional areas of the province—is such that medium- and longer-term solutions simply can't be waited for to solve current needs.

The second issue is with respect to who plans, and that's the question we're trying to address. In our view, the district health council process which Mr Wessinger has alluded to is probably appropriate for questions surrounding primary care issues and other issues which

can be specifically addressed and studied and where the analysis can be done at the local level by all participants in the community. There are certain areas of health care, however, which expand beyond those boundaries, which go beyond the regional boundaries. I believe they are the specialty areas, including cancer care, cardiology and kidney, among one or two others. The district health council process was neither devised nor designed to deal with those areas of specialty care which require significantly different inputs in terms of analysis, in terms of treatment delivery and in terms of supportive care, and the issues around those.

In my view, the call for an agency was heard by the committee on more than one occasion. My impression from discussion before the committee was that a formal agency, a formal new body, wasn't what was seen as necessary. However, what was seen as necessary was a permanent mechanism, and I stress the word "permanent," that will on an ongoing basis ensure that longer-term planning, analysis and research is done in a coordinated way.

Our approach is in many ways comparable to the government's own approach in bringing together a network of experts associated with cancer treatment. The regional outflow from that central network activity can certainly ensure that on a regional basis, the local delivery is put into place.

Clearly, there is not concurrence with the approach we have put. We believe it's reasonable, we believe it's appropriate. We believe it also is supportive of the recommendations and moves on from the recommendations included in the committee report and therefore would like it appended as a minority report.

Mr Jim Wilson: I would urge the Liberal caucus to reconsider. I think some of the concerns Mrs Sullivan has brought forward are addressed in the recommendations that have been agreed to by all three parties of this Legislature in this committee.

Recommendation 4, if I may just read it, says that: "The Ministry of Health develop mechanisms for disease-specific and needs-based planning. The officials and branches responsible for this planning must be clearly identified to legislators and the public."

I felt we had reached a very good consensus with respect to the ongoing planning. We have thousands of bureaucrats over there, and surely to goodness they could do a bit of planning. If they can't, we should fire them and get some people who can do some planning. We don't need to set up more committees and tiers.

If there's a problem that the Ministry of Health is unable to plan—and I agree, the Ministry of Health doesn't seem to be able to plan—then I suggest we get a new minister and we fire a few people, or rather than firing everyone, I suppose we could bring a few people in on secondment, which is a program my party used to do on a regular basis when we were in government. It was not uncommon to borrow experts from the private sector, from the hospital sector, and to have them come in and run parts of your ministry for a while. That was just a commonsense way of doing things and it also kept the payroll costs down. That's all gone. Maybe we should

bring it back. But all three parties agreed on recommendation 4 because we didn't want to see another whole layer and bureaucracy duplicating what the Ministry of Health is supposed to do. If the Liberal caucus wants to come forward and say the Ministry of Health isn't doing what it should be doing, we'll talk about that, but I think we have to give the ministry a chance. We're giving them a recommendation. We're telling them to get their act together here, and we're making sure that they clearly identify that role and responsibility to legislators so that I and other members in the future who want to deal with this issue or other disease-specific crises that pop up in the province will know what bureaucrats and what branches of the ministry are specifically responsible for that planning. I thought recommendation 4 was very positive and I thought it addressed a number of the concerns Mrs Sullivan has raised once again.

Recommendation 5 is that "The Ministry of Health, in consultation with the Kidney Foundation, specialists and other stakeholders, develop a kidney patient registry in Ontario."

To me, that was a very significant recommendation. We heard a fair bit of testimony regarding the need for a patient registry, and I think, Mrs Sullivan, some of your concerns about coordination and other things you mentioned will be addressed through the patient registry, and I look forward to the Ministry of Health's response on that.

I think it's something that will be agreed to by the government—at least I hope it will—and will help with that long-term planning so we don't have these surprises of patients appearing from time to time for whom governments claim they weren't prepared. If we have an ongoing registry of patients and if we have that registry from prior to end-stage renal disease and follow the progress or deterioration of patients throughout the stages of disease, we'll be able to plan for and anticipate the needs when a patient does eventually have end-stage renal disease or kidney failure.

I think we've covered those angles, and I don't want to see more committees set up that in any way would detract from what has been a very difficult process to date, that is, to get the government to agree to fast-track what it already has in place, not to create new bureaucracies but to make sure that the people who are currently on the payroll do what they're supposed to be doing for the people of Ontario.

1700

The Chair: Mr O'Connor wanted to add something briefly. As I say, any member may submit a dissenting opinion, and I think the views have been expressed.

Mr O'Connor: To wrap it up, in the minority report there are some presumptions made that a lot of these areas won't be touched on by the working group. But a lot of what you've raised will be touched upon by the working group and by the Central East Regional Dialysis Committee. I see we're not going to agree on this, and I just pass that on.

The Chair: I think we'll move to adopting the report. As I say, if there is a dissenting opinion, that can be

added to it. What I propose to do is I'm going to move the adoption of the report, and I'll just note that that includes recommendation 15, which deals with the question of the response within 120 days.

Does the committee agree to adopt the report on dialysis treatment services, as presented?

All those in favour? Opposed? Carried. The report is adopted.

Having adopted the report, I need the following agreement. Shall I present the committee's report to the House, simultaneously in English and French, and move the adoption of its recommendations? Agreed.

Before you, you have the letter we had agreed I would send on behalf of the committee, if I can read that into the record. Mr Wilson made reference to it in his comments earlier.

"Dear Minister:

"I am writing on behalf of the standing committee on social development with respect to our recent consideration of dialysis treatment services in Ontario.

"In the course of the committee's hearings, a number of concerns were expressed by presenters with respect to the cases of particular individuals and their difficult circumstances in obtaining dialysis treatment. The committee has directed me to request that you review the concerns raised and endeavour to find appropriate responses for those individuals. I enclose for your information the transcripts of the committee's proceedings.

"The committee further directed me to request that you provide directly to the committee within 30 days following the tabling of the committee's report on dialysis treatment services a written status report on your review of the individual cases and remedial measures taken.

"Your review of these concerns and considerate response is appreciated by the committee.

"Yours sincerely,

"Charles Beer,

"Chair,

"Standing committee on social development."

Mr Jim Wilson: I think it's a very good letter, Mr Chairman, and would just ask that the cc's and the names of the committee members to whom this is to be copied be included on the letter.

The Chair: Fine. Is that letter agreeable to all members? Okay, that's agreed, and I will send that out as soon as we can get that typed up. That concludes our hearings on the section 125 regarding dialysis treatment that was brought by Mr Wilson.

Just before we break, Mrs O'Neill, Mr Jackson and Mr Owens have received a draft list of witnesses for the section 125 we are going to begin on May 16, regarding children at risk. I think the subcommittee can deal with those, and we will get letters and phone calls out to the people who are going to be presenting.

I'd also say to members that the Premier's Council has

been confirmed for Monday. We would meet here on Monday of next week, the 9th, at 3:30. We would not meet on Tuesday, May 10.

Mr Jim Wilson: Mr Chairman, just in conclusion, I think I would be remiss if I did not thank you on behalf of my caucus colleagues and I for your excellent leadership during these committee hearings. I had the opportunity—I don't know whether you were listening—to say what I thought were some complimentary things about you in the House last week in terms of your ability to chair this standing committee. I think it's long overdue that I personally thank you for the excellent job you do. Having served on other committees and having had various Chairs from different parties, I would say that indeed you're the best Chair I've served under. Now I'll botch up your mailing to your constituents, I'm sure, by suggesting that you might mail this to your constituents, but none the less, thank you.

In particular, I'm impressed with the way you make difficult situations easy for all of us. It's never easy when people with very emotional stories come before this committee and tell us about their lives. You have a natural ability to put people at ease. I thank you for that and for the leadership you've shown us.

Mrs Sullivan: Hear, hear.

The Chair: Thank you very much.

Mrs O'Neill: Mr Chairman, I would certainly concur with those remarks.

The Chair: "However," she said.

Mrs O'Neill: No, I have a question. The report now has been accepted by the committee. Is it now public?

The Chair: No. It will be when I present it to the House. At that point it will be public, and we'll be able to do that within the next couple of weeks, at most.

Mr Wessenger: Mr Chair, could I also add my congratulations? Just so I don't get into trouble, I would say that the Chairs I've served with in the social development committee I've always found to be excellent.

Mr Jim Wilson: Be specific.

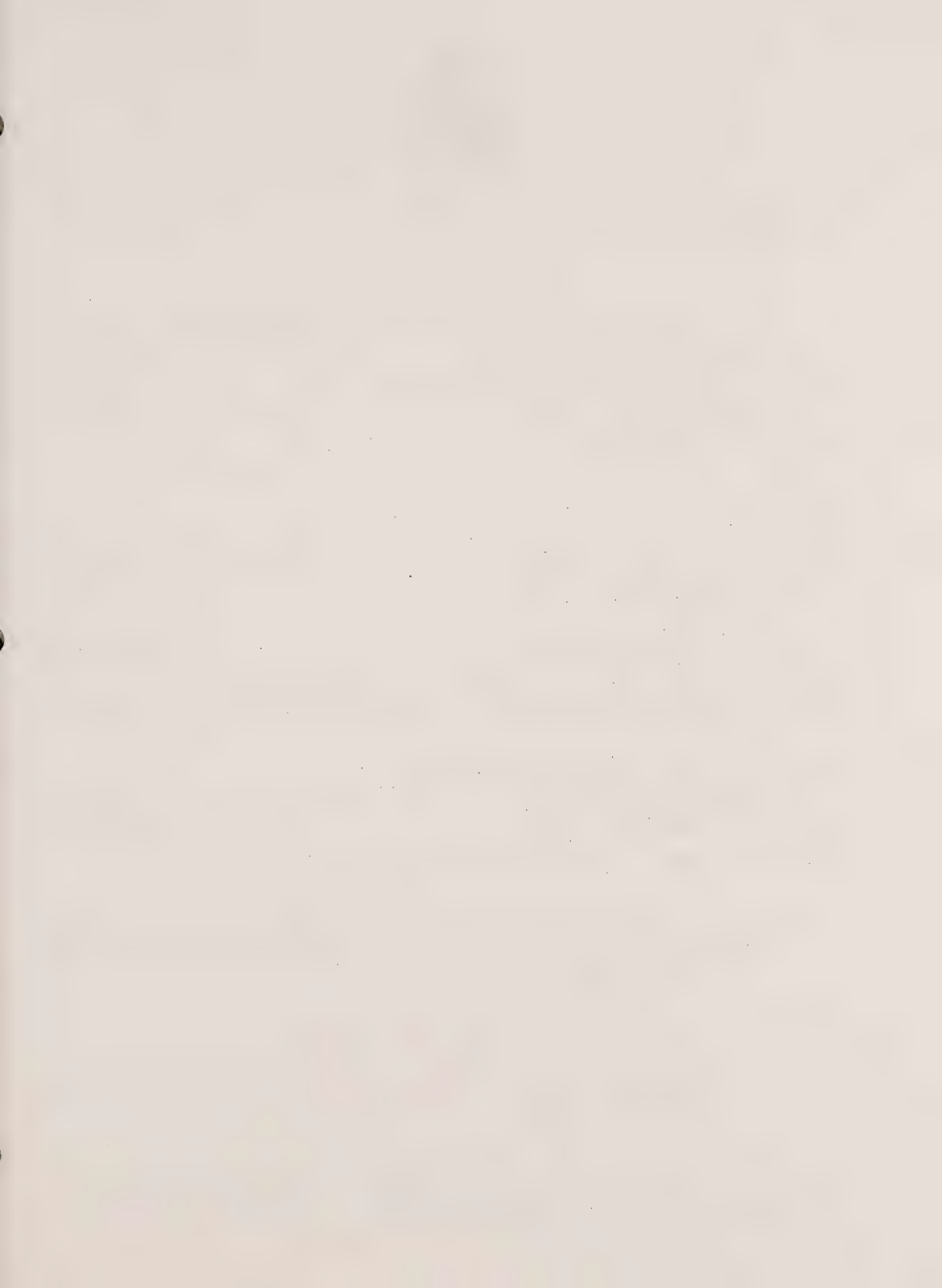
Mr Wessenger: There were two committee Chairs and I found them both to be excellent. But I must compliment you in helping us reach the consensus on this report. It was very much appreciated, and I concur in appreciating your sensitivity in dealing with this issue and with the witnesses.

The Chair: I should undoubtedly add that never have I worked with such a nice group of committee members.

I might too, just on the committee's behalf, thank all of the staff who have assisted us with the committee. You'd understand particularly if I mentioned Bob Gardner, who took our words and put them into a reasonably articulate whole. We want to thank everyone and to thank the witnesses who came before us.

With that, the committee will stand adjourned until next Monday at 3:30.

The committee adjourned at 1708.



CONTENTS

Tuesday 3 May 1994

Subcommittee report	S-1463
Draft report: Dialysis treatment services	S-1463

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- ***Chair / Président:** Beer, Charles (York-Mackenzie L)
- ***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- *Carter, Jenny (Peterborough ND)
- Cunningham, Dianne (London North/-Nord PC)
- Hope, Randy R. (Chatham-Kent ND)
- Martin, Tony (Sault Ste Marie ND)
- McGuinty, Dalton (Ottawa South/-Sud L)
- *O'Connor, Larry (Durham-York ND)
- *O'Neill, Yvonne (Ottawa-Rideau L)
- Owens, Stephen (Scarborough Centre ND)
- *Rizzo, Tony (Oakwood ND)
- *Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Sullivan, Barbara (Halton Centre L) for Mr McGuinty
Waters, Daniel (Muskoka-Georgian Bay/Muskoka-Baie-Georgienne ND) for Mr Martin
Wessenger, Paul (Simcoe Centre ND) for Mr Owens

Also taking part / Autres participants et participantes:

Wessenger, Paul, parliamentary assistant to Minister of Health

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Gardner, Dr Bob, assistant director, Legislative Research Service



S-50

S-50

ISSN 1180-3274

**Legislative Assembly
of Ontario**

Third Session, 35th Parliament

**Assemblée législative
de l'Ontario**

Troisième session, 35^e législature

**Official Report
of Debates
(Hansard)**

Monday 9 May 1994

**Journal
des débats
(Hansard)**

Lundi 9 mai 1994

**Standing committee on
social development**

Premier's Council on Health,
Wellbeing and Social Justice

**Comité permanent des
affaires sociales**

Conseil du premier ministre
sur la santé, le bien-être
et la justice sociale

Chair: Charles Beer
Clerk: Doug Arnott



Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Monday 9 May 1994

Lundi 9 mai 1994

The committee met at 1536 in room 151.

PREMIER'S COUNCIL ON HEALTH,
WELLBEING AND SOCIAL JUSTICE

Pursuant to standing order 108, consideration of the report of the Premier's Council on Health, Wellbeing and Social Justice.

The Chair (Mr Charles Beer): Just before calling our witnesses who will be appearing before us today, I'd like to note a couple of things. It is appropriate that we are going to be meeting with representatives from the Premier's Council on Health, Wellbeing and Social Justice. As members know, we begin next week a series of hearings under section 125 dealing with children at risk, and just for members of the committee, I'd like to ask Bob Gardner if he would review some materials that have been circulated.

Dr Bob Gardner: Members asked earlier on for the 1991 report that the committee did on children's mental health services, so we've included that. You didn't ask for anything else, but we brought some more background material anyway. Joanne put together a range of articles and excerpts from reports on the three issue areas that the committee will be looking at: the question of physical and sexual abuse, children in need of protection under the Child and Family Services Act, and then the broader issue of children and poverty. So you'll find in the package a range of articles and reports and so on.

The Chair: Thanks very much. Those hearings will begin next Monday here at 3:30.

We turn then to our order of business today. Under standing order 108 we have invited representatives from the Premier's Council to come and to go through with committee members the document they have today released and which was tabled in the House: Yours, Mine and Ours.

I invite Marilyn Knox and Dan Offord to come forward. Welcome to the committee. We are really delighted that we had a free day today and that you were able to stay longer. I think we all sense that this is a very important report, and this provides not only an opportunity for us to better understand it but, as we are here in the Amethyst Room with television, I think also to get the message out to a broader audience.

I wanted to say to you at the outset that we are very much in your hands in terms of how you would like to proceed. I know that there are some other people in the room today with you who have been involved in different aspects of this document as well as the youth document. I think I speak for committee members in saying that if

at some point you'd like to invite others to the front to discuss some of that, that is fine and we'd be quite happy to do that as well. But you take us through as you feel is appropriate. At various points we may have a few questions and so on, and we'll just take it from there.

Perhaps at the outset you would also both be good enough, in terms of Hansard and the viewing audience, to just identify yourselves and how you came to be here this afternoon talking about this report.

Ms Marilyn Knox: Thank you very much for inviting us, and to you particularly, thank you for the remarks we heard from you today as well as the other parties. We appreciate the opportunity to sit and talk with you as this report is just hot off the press: what we did, what we're thinking about and what we've yet to do with this report. I'm Marilyn Knox. I co-chair this committee. I'm from the private sector.

Dr Dan Offord: I'm Dan Offord. I'm from McMaster University and I'm a child psychiatrist there. I co-chair the committee with Marilyn.

Ms Knox: There are some 17 of us who have been involved with this at the committee level, with Jane Fitzgerald behind us being the prime mover on the staff side, as well as her deputy, Tom—did Tom leave? There he is—and Malcolm, Chung and Zenia from the Ontario Coalition for Children and Youth. Malcolm works with them, and Dave. They may feel free to jump in at certain times as we go through this.

What we thought would be useful is to give you an overview to start with of what's in the report, and we'd like it to be very informal. If at any time you want to jump in, please feel free to do that. Does that make sense?

The Chair: Absolutely, and because there will be people viewing this at different times over the next number of days, if people want to get a copy of the document—it's something we always forget to do—but could you indicate right now what they ought to do and can everyone remember, before we finish, that we do it again so people will have some idea? I'm assuming they can phone or write to the Premier's Council, but could you read out the address?

Ms Knox: Sure. Copies are free and they're available in English and in French from the Premier's Council on Health, Wellbeing and Social Justice, which is at 1 Dundas Street West, 25th Floor, Toronto, Ontario. The postal code is M7A 1Y7. They can call to 416-326-6754 or they can fax to 416-325-4261.

We have a report here that's two years in the making.

It's called Yours, Mine and Ours: Ontario's Children and Youth. It is the first phase of a three-phase program, so the work is not finished yet. The report is there, but it will be followed by a community mobilization campaign and something we're calling the report card. We'll talk all about that as we go through this.

The two years in the making was not original thinking work, but it was rather taking the best of work that had been done by governments in the past, by researchers in the past, by community people in the past from all kinds of disciplines. It was really pulling together a huge amount of work that had already been done, taking discussions with children, youth, parents, grandparents, specialists, people who are volunteers, a huge number of people who gave us their views.

Very simply what we've done is a diagnosis on the situation of children and youth in Ontario today, developed a framework that's simple, that anyone can understand, on how to approach the problems and some ideas about what the solutions are and some ways to measure the results. In essence, that's what this report is all about.

Dr Offord: I'm going to start with a slide here. Let me just talk to this slide, because it provides a framework on which the report is based.

I'll begin at the bottom, healthy child development, and move up the left-hand side of this circle. What you hope for in Ontario is that children experience healthy child development. They become healthy children and adolescents and because of that, when they enter the workforce, the workforce itself is capable of innovation and is a competitive workforce. The result is a prosperous society. There's social stability. Because of these two things, there are resources to fund programs that foster healthy child development. That's the kind of circle that we hope happens.

What's bothersome in Ontario is that as you go up the left-hand side of this circle, there's a growing and growing group of children who are losing out early on in their childhood. These are children who experience early school failure and have behaviour problems beginning as mild anti-social behaviour and growing into severe anti-social behaviour, school dropout, alcohol and drug abuse.

There's a lot of money and resources being spent trying to reduce the scope and magnitude of this what might be called "casualty" class of children. Of course, when they grow up, in many instances they're not fully functioning members of society, so they can't contribute as much as they could otherwise do to the prosperity of society. The workforce is not as competitive, the place is not as prosperous, and there are very few funds left over to support these programs.

Now, this circle has two or three implications. The first is that the size of this group of kids who are losing out is so immense that the kind of work that I do clinically, seeing kids one at a time, attempting to help them, is unlikely to make a major impact in reducing the burden of suffering. The scope and magnitude is simply too large. One has to think of interventions that will affect groups of children.

The second thing is that this program is of such

importance and size that it's not just people like all of us in the room concerned about kids today who are concerned, but almost all the sectors of society are concerned with this problem. It's interesting, in our experience on the Premier's Council, that some of our strongest advocates for this initiative have been from the business community, who are saying, in a sense, if you just put social justice to one side for a minute, unless we do something about this problem, it's not just those kids and those families who are going to have difficulty, but my kids, the whole next generation, who are going to have a lower life quality than we have.

The third implication to this is that one can argue that when times are tough, when things aren't going well, when a workforce is not leading to prosperity, one kind of program you don't want to cut is that which fosters healthy child development and programs that can contribute to reducing this casualty class. If you can do that, that appears to be one of the most hopeful ways of getting out of the recession, because in a way you have a much more prosperous and innovative workforce.

Ms Knox: As we went about looking at the situation that we find ourselves in today, families, time available, the economy all have gone through their own kind of restructuring and change. The institutions that support healthy child development have not gone through as much change as those other sides.

You see, of course, families are changing. You look at the percentage of women with children under six who are working; it's over 60% now. When you look at the social climate that has changed, what has now happened to the real income of families where the major breadwinner is 25 and under, versus 10 years ago, is that it's substantially less.

We believe there is a perception of increased violence. Whether there really is or not, we haven't measured it, but the perception would certainly be, if you look at downtown Toronto and other communities, that violence is on the upswing.

You know, of course, that the role of women has changed.

There are some other things. The economy and indeed governments are undergoing restructuring. Lifelong learning has become extremely important. The other Premier's Council has talked about the need for that. But when you look, in companion to that, at the dropout rates from high school, the functional illiteracy rate in our society, those things don't bode well for a society that has decided that not only is lifelong learning important, but it looks like a majority of jobs down the road will require more than secondary education. Those things start to make us worry about what's going on: families are struggling harder to stay afloat financially, the time crunch we talked about, and increasing cultural diversity.

1550

So what are the things we must do and where should we begin? We began with a set of beliefs—and it's important to understand the starting point—that we see children and youth as important for who they are today in addition to the investment they are in the future. They

are an important part of our society. Healthy children and youth are absolutely beneficial. Dan's already discussed that. We're not trying to say that the primary responsibility for kids isn't their parents, but that those parents need support. We also are saying that children and youth, and that came through very strongly from the Ontario Coalition for Children and Youth, want an opportunity to participate. All children and youth must grow and develop free of violence, discrimination, abuse and inequity.

Those are the fundamental beliefs we share. Also, a stable and adequate economy is important, and when that falls apart, the kids are affected as well.

What did we hear? We went out and talked with a lot of people. First of all, we did focus groups, 22 of them around the province, talked to children from five years all the way up to parents and grandparents to the age of 85. In that age range, it was quite remarkable to see what happened. I think it was important to have started with the very young kids and not to forget the grandparents.

There are certain central themes. The kids from five to 10 were very straightforward; they told us exactly what they thought. After 10 years old, they started to tell you a little bit more about what they thought you wanted to hear, and also the cynicism started to come in.

But the sad part is when you really asked youth, "What are your dreams, what are your aspirations?" When we were younger, and I remember when our parents used to say that, it was perhaps to have the great travel adventure or the scientific discovery or the great art piece, but these kids said, "We want to have an income, we want to have good relationships with our families and friends, and we want a degree of freedom and independence." If you look at what the determinants of health are, those are very healthy answers, but have we taken their dreams away?

What the parents were concerned about was being able to provide for their families economically, and what that started to do was introduce even more of a time crunch.

What the grandparents said was: "Oh, don't worry so much about the money. Give them time. And what's more, we can help you with the time." But in reality, the way our society is organized at the moment, are the grandparents in the same place as the parents and the same place as where all those kids are? It's not quite as simple as that.

These were the things we heard when we did the focus groups at the very beginning.

We also asked the Ontario Coalition for Children and Youth to become involved. We sat around our table in the early days and said, "We should have our youth representatives on our committee." We tried very hard, we got a few representatives, and then they went on with their lives, things happened to them, and it was hard for us to get someone who was participating with the committee at all times.

Then we thought: "Is that really accomplishing what we're trying to do? Perhaps what we need to do is to figure out a way that is ongoing and get a huge input from children and youth, not a token input." That's when it was our good fortune to have discovered the Coalition for Children and Youth. They went out and conducted 21

sessions around the province, north, south, east, west, and in every kind of mixture you can think of. They came out with a whole lot of observations, some of them contradictory, definitely honest, some bold, some of them just very much what you'd expect, but they boiled it all down to four big recommendations.

—First, ongoing involvement in meaningful decision-making in areas that involve them. This is a very important thing to think through. It's not a command that they have a seat on the board of everything. It is a very thoughtful request. If programming policies are thinking about children and youth, why not involve them in the thinking?

—Second is to have a provincial network for children and youth, and they may want to speak to that.

—Third, better preparation for the adult world, if you think about the life skills that are required to function, the number of careers that youth today will probably have down the road. There was another thoughtful recommendation about skill sets, for us to be better skilled at parenting. The skill set recommendation focused on them, but they had another thoughtful recommendation.

—Finally, to be portrayed more realistically, by the media as well as politicians.

Did you want to add anything?

Ms Zenia Wadhvani: No, you did a nice job.

Ms Knox: So what do we know? We're going to go on and talk about the research.

Dr Offord: This research led us to some key assumptions. The first is multiple pathways for healthy human development.

The way to understand kids growing up in Ontario is that when they start off they're like on a train track. They go down that train track, and almost without exception some kids get off of it a bit, and then they get right back on again, they mature out of it. One doesn't have to explain why kids have some symptoms and some difficulties. The issue is that most of them get right back on it again, and there are different ways in which they get off and different ways in which they get on.

Ms Knox: What's an example?

Dr Offord: I think almost all kids in this province and all of us back in our childhoods did some anti-social behaviour. We always did. Everybody smiles and says, "Oh, I did some."

Ms Knox: It's hard to imagine that Charles did.

The Chair: We did.

Dr Offord: We did, sure. So you don't have to explain why kids do it, but why is it that some kids start off and don't stop? It's not under control.

Mr Cameron Jackson (Burlington South): They go into politics, the ultimate acting-out.

Dr Offord: Right, I got you.

The second thing is that development occurs within various environments. There's one inside of us, there's also the one in the family, but it's not just inside of us and the family. There are other contexts that we know are important for kids—the schools, the community—and a

lot of these other contexts can make up for a lot of difficulties in the family, for instance. That's why it's so important for kids who are having difficulty in the families to have the best outside-the-home programs the province can provide in contexts such as recreation, schools etc.

The prenatal period and early childhood are crucial times, that's true. Earlier is probably better, but that has to be tempered with an understanding that there are different points at which one can intervene in the lives of kids that can make a difference. All of it doesn't have to be early on. Human development evolves in phases, and we're going to point out in a minute that there appear to be certain points in the growing up of children where one has a better chance of having success if one intervenes at those particular points.

And there are determinants, that is, factors that determine how successful kids are going to be in navigating these particular phases. What we did through the research papers was say, "Let's think of what criteria we'd apply if we were going to focus on certain determinants," because there are many things that influence how kids grow up. We applied certain criteria to narrow down the number of determinants or influences we wanted to consider.

First, we thought the determinants should be amenable to public policy.

Second, it should be a determinant that involves all children and youth, not just specialized or high-risk or particular groups of kids.

Third, one could envision that if one could do something about it, it could be done at reasonable cost. If you have unlimited funds, you can do a lot, particularly for small groups of kids, but if you're interested in raising the life quality of groups of kids, then one has to be very concerned about cost.

Fourth, there has to be a concern with measurable progress; that is to say, we want to know whether things have got better or got worse and whether we've had some success.

The last one is specific to the council, a determinant we thought: that by pressing for change, we could have some role in facilitating change.

As I mentioned, we focused on four points of transition, and these are period where one probably has a better chance of shifting the trajectory, the life course of kids.

The first is transition to life. It extends from the prenatal period through to the end of the first year. The second is transition to school. The influences include all the preschool years; the point of transition is between preschool and entering school. The third is transition to adolescence, and that corresponds generally with the change from senior public school to high school. The last is transition to family, the work roles and community. It's leaving high school, either to go to work or to go to some higher form of education.

This is the model we use. We say, let's focus down on determinants of successful navigation of these transitions, and then if we can identify a limited number of these determinants, we can, based on those, recommend some

actions that could be carried out at the community level widely in Ontario.

Next, we want to be able to measure the effect of this: If these changes did take place, what are the measurable changes in the outcomes of kids?

Last, we want to put these outcomes together—and I'm going to talk about this in a minute—in terms of a report card, so that a community, the province, or different subgroups in the province would know how their kids are doing, from one year to the next and compared from one jurisdiction to the next.

1600

Let me run briefly through these transitions.

First, the transition to life, the two major determinants of having healthy infants. The first is that you have healthy moms, and the second is that there's comprehensive care before, during and after pregnancy. Based on those determinants, we have two recommendations for that transition point.

The first is that we want to ensure that all women have access to good prenatal and postnatal care and support, so services to pregnant women and new mothers should be in a coordinated and accessible service network at the community level, and it has to contain a comprehensive range of services—not just the usual health services, but social and parent support services.

The second recommendation is to promote a healthy and supportive birth experience for all women. To do that, communities should have a range of birthing options that provide equitable access to a choice of birthing services. Some young mothers want to have their babies in hospitals, some do not, and there has to be a range of possibilities that the expectant mother feels comfortable with.

Mr Jackson: Does that include high-risk births as well, the other end of that?

Dr Offord: Yes, it does include that. There what you would need is to have the specialized services needed for these particular subgroups of people. The community would have a wide range of services, but in the case of high-risk pregnancy, you'd certainly want the backup of specialized care.

Then we have the outcomes: If that works, if you get those two in place, what would you expect changed? Well, we haven't worked out all these outcomes, but these are some initial attempts at these. The percentage of low-birth-weight babies could be reduced; and if we could find a measure—we're working on it—to measure the health of kids at one year of age, and that will include the type of attachment they have with their moms. The importance of such outcome measures does not just tell you something about the health of the one-year-old, but deviations at that age, of course, can put kids on different trajectories that have long-term influences.

The second transition is the transition to school. What are the two major determinants of successful transition to school? The first is that you've got to have high-quality care during the preschool. Second, you've got to find ways of preventing injuries to kids during the preschool era.

The first recommendation, the third of our overall group of recommendations, focuses on having work-friendly places for young mothers, young parents. This recommendation involves not just the usual child-caring sector but now brings in the business and employer sector. They'll have to find ways to make it possible for young mothers to feel comfortable working and looking after their kids, through things such as flex time, having time off to go to school conferences, having time off to stay with their kids when they are not feeling well.

The second recommendation is to ensure that all children receive good care and stimulation through the preschool years so that when they enter grade 1, they can master the work cognitively and they can master the environment behaviourally. What happens in this province, for instance, is that there are groups of kids who are very much behind when they enter grade 1. Some data suggest that some groups are one and two years behind in mathematical skills, basic number skills, so when they enter grade 1, of course they're in bad difficulty because the school offers a certain curriculum to them but these kids are unable to take advantage of it.

Ms Knox: And what happens to those kids if they don't get caught then?

Dr Offord: What happens is that in many cases they fail grade 1, they get turned off school, their parents feel alienated from the school environment, particularly if the kids themselves feel the school has treated them badly. And it's just not the failing of grade 1, but they're on a course now into special class and all that sort of stuff that puts them at much higher risk than they would be if they got off to a good start in school.

Mr Larry O'Connor (Durham-York): Would you find certain communities in which this was more of a problem, as the focus groups and everyone helped you develop towards this recommendation? Was this more common in certain communities, and what type of communities would they have been?

Dr Offord: There are not good data on this in all communities. That's number one. We'd like to know that; that's one of the things the report card will tell us. But information from Ontario and other places suggests, for instance, that children in public housing communities, these kids as a group—it doesn't mean all of them, but as a group—probably have severe difficulty accomplishing satisfactorily in first grade compared to other groups of kids.

Here is a major challenge in this province. What could you do to make it possible for these kids to get off to a better start in school? Clearly, part of the answer is that there's going to have to be a working together in those communities to ensure that these kids have a stimulating and stable environment during the preschool years. The other side of it is that schools are going to have to become very skilled at dealing with these kids who may make come into kindergarten and grade 1 with different prerequisites.

Mr O'Connor: I represent a rural riding. Would that be more of a problem there?

Dr Offord: That's a good question. The answer is

that we don't know. We know from our work that rural teachers, teachers in rural schools, don't see high-risk kids as being as troublesome as they do in urban schools. They appear to be much more tolerant. This is back in the mid-1980s—whether that holds today or not. Your point is well taken. To what extent the deficit occurs in rural communities compared to other areas in the province, I don't think we know. We'd like to know that and I'm sure you'd like to know too.

Mr Jackson: Did you look at all at differentiated entry points, because that's something that the select community on education examined. Richard Johnston was a member of that with me, as I believe Mr Beer was at one point, and we looked at that very seriously.

Dr Offord: We did not, in our overall; maybe in the subgroup, the task force, that was examined. I don't think we considered that in our discussions. Do you mean that different groups of kids would enter the formal school system differently?

Mr Jackson: The identification of children at risk is something we know we can do. It's just that no one has the responsibility to do it because the school board says, "It's our responsibility when we get the money from the province and the taxpayer to do it, but until we get that"—

Dr Offord: It's tricky. Let me tell you what I think the data show. You can identify kids who are going to do badly at the end of grade 2; you can identify them at age four and five. The problem is that to get all the kids who are going to do badly in grade 2, you're going to be wrong half the time, because your group has to be so big, if you see what I mean. The net has to be pretty wide.

It's important to think about identifying high-risk groups, but also to keep in mind that it's not an exact thing and that you're going to be wrong a lot of the time. One of the things this report emphasizes is to say, are there some interventions that could be applied on a community-wide basis that would cut down, in the first place, the number of kids at risk and not wait for these kids to become at risk before trying to do something about them? It's an area we're particularly interested in, but it's very difficult to predict the behaviour of kids. To get the group you want, you've got to make the net pretty wide. There are a lot of false positives there.

Ms Knox: When you get to the point of looking at the outcomes that we want to measure in transition 2, in a community, let's say, if you were looking at certain markers on an annual basis of what's happening about your kids in your community being really ready for grade 1, it would start to tell you, "If you're off the mark compared to other communities, in your community you may want to focus on that and the entry into junior kindergarten programs, the quality of child care and so on, the training that people get who are looking after children, whether it be parents or people in the home, in addition to child care licensed people." Those things will start to tell you what you need to do in your community to make things better.

Do you want to talk about the Operation Headstart results for a minute?

1610

Dr Offord: Headstart's an interesting program. The evidence is clear that if you have the money, you can raise the IQs of poor kids, economically disadvantaged kids, and get them off to a better start in school. The data were discouraging to the extent that if you follow those kids up until grade 4, you find that the initial advantage the kids had compared to the comparison group that didn't have the preschool washed out. By grade 4, these kids could not be distinguished from the kids who never had preschool in the first place. That was very discouraging to people and they said, "Jeez, we're giving these kids something and it doesn't seem to last," and that's not surprising, because these kids need it.

Then the oddest finding came up. If you follow those kids up until age 19—now they're followed up to age 27, actually—you find that the kids who were in preschool were at some advantage over the other kids at age 19, in the following ways: They were less likely to be antisocial, were doing better in school, were less likely to drop out and were more likely to have a good work history, and that's continued up into the mid-20s.

There's something nuts here because you've got an intervention at ages three to five, the effects pass out by the age of eight or nine, and then there are the long-term effects.

The way to understand those: First of all, are they lying? Is it the truth? Apparently, it's true. They understand that by always considering the concept of pathways, that it's not just what you do for a kid at the time but it's the kind of pathway you put a kid on.

What happened to these preschool kids are two things. We understand more about the first than the second. The first is that what the preschool did was that it got the kids off to a much better start. They never went into special class early on. They were doing so well in the first three grades of school that the teacher never thought of putting them into a learning disorder class or a behavioral class or whatever. Once you get in those kinds of classes, it's a different trajectory.

The second thing these preschools did for these parents was that they became empowered about taking on the school system. They felt very comfortable going to the teacher and fighting for their kids. They were less likely to be, in a sense, pushed to one side by the school system.

The importance of this finding is that it illustrates that it's not just what you do for a kid at the time, but you always want to think of what the possible pathways you've opened up to the kids might be, and it's through those pathways and understanding those trajectories that one can understand the long-term effects of an early intervention.

Mr Jackson: It also tells us something about the junior division in our school system, which is lacking, that you won't find in our primary division, in terms of PTR, in terms of resources, in terms of training. There's this gap and then it gets all stimulated again in the intermediate division on your way to high school. There's sort of a gap in there, and this lull is probably what's

occurring there, in my view. Forgive me for interrupting.

Dr Offord: No, that's fine.

Ms Knox: There's the parent relationship with the school.

Dr Offord: That's the other thing we were discussing at the press conference, the parent relationship with the school. It's a fascinating thing. I'd be interested in knowing your experience in rural areas.

In some schools, and we've gone to 60 of them as part of this big project, the parents feel very comfortable going to the school. It's a very friendly place. We were trying to set up parent training courses. We'd say, "Where would you like to have them?" Some parents would usually say: "Have them in the school. Everybody loves going there." In other communities, the parents and the school would say, "For heaven's sake, don't have them here; parents hate it here," and the parents felt very uncomfortable coming to the school.

There's beginning work to suggest that when you have this lack of communication and an adversarial relationship between the home and the school, you're in trouble. One has to think of ways to make sure that parents, particularly parents of kids who are at increased risk, feel very comfortable coming to the school and talking with the teachers about their kids etc.

I mentioned there's a research project in Oregon. One of the things that teachers in Ontario complain about all the time is that there's no phones in the school. They can't phone home. Kids don't like it and they all complain about it. This guy in Oregon got a really smart idea. He had research funds in the States, and as part of his intervention he got money to put a phone in every classroom. Every day the teacher leaves a taped message—this is a very high-risk, inner-city area—for the parents on what's been going on in school that day, what the social skill of the day is, what they're covering in school and how they can help out.

Of course they've monitored it and almost all the parents call daily to find out what the news is from the school. Not only that, I think it's about 80% of the parents leave a message every day for the teacher about how their kid's doing. I think this is a creative, innovative way of trying to find ways of bringing the home and school together, but these are two major contexts in kids' lives, and the more they can be brought together, the better off the kids appear to be.

This is the outcomes at the end for transition 2, showing that they're ready to learn in grade 1 and have an age-appropriate set of social skills. We're going to have to operationalize that outcome better. We've got a lot of work to do in this area. This is just our first attempt.

Moving on to adolescence, the major determinants are to have supportive environments for these kids and to give them some control over decisions and choices. Most of the impetus to try to help teenagers is to try to stop them from doing things: stop drinking, stop this, stop that. The overwhelming evidence of that stuff is that it does not work, and in some cases it may promote the activity. So one has to think of different ways of ap-

proaching the kinds of difficulties these kids potentially can get into.

Our first recommendation here is "to create supportive environments for children and youth, improve their ability to participate effectively, and enhance their sense of belonging," and really to turn elementary schools and senior public schools into what we could call community schools.

This is really a very exciting possibility that's happening in some communities, where the school becomes the centre of community activities for not only the kids but the parents. I've talked about the development of partnerships between the school and the community. The school doesn't close at 4; it's not closed on the weekends; it's open. There's community participation in the schools, and learning life skills is part of the school experience. You can see how important the public school or the elementary school principal is, because some principals and staff enable the whole school to be opened up, where the community participates and things go on with the school at the centre.

The second recommendation for this age group is "to increase opportunities for supportive relationships for children and youth." What these kids need, of course, is a chance to talk things over with some adult—it doesn't have to be a teacher, but some adult; it could be a senior citizen, it could be somebody in the business community—who has a mentoring relationship, somebody who could check with the kid about how things are going, what possibilities there are for him or her and what choices there are and how they could be helped along.

A lot of this happens informally anyway, particularly for kids who have everything else going for them. What's needed is to think of a way that this kind of thing could be delivered for populations of children, really adolescents now.

For the outcomes here, we've thought of some. These are kids entering grade 9. Level of academic achievement: You would hope that there would be a reduction in violent incidents and expulsions and that the kids would have a lower rate of absenteeism.

The last transition is the transition to work roles, community and family. What's needed here is family support and some very solid, supportive relationships or links between the education network and the workplace.

Our first recommendation for transition 4 is to give the youth a lot of opportunities to contribute to the community. There's good evidence to suggest that for those of us who volunteer as adults, almost without exception that began in childhood. So the volunteering pathway begins in childhood and in adolescence, and we want to have some way of making sure that adolescents have the opportunity to contribute back to their community.

What we're suggesting for this transition is that there could be a way in which youth could get together, and maybe Zenia and Chung can talk about this, a youth mobilization program where they would have their own ideas as to how that could be brought about at the provincial level. We think it important to have a community service credit in all secondary schools so that

when kids do something for the community, they get credit for it.

There's some evidence that peer mentoring works; that is to say, older kids in secondary school mentoring younger kids appears to have beneficial effects. The unanswered question is whether this really extends beyond kids that have everything else going for them anyway. Does it really get at kids who are having difficulties? We're also suggesting that youth representation on the governing boards of agencies and other community bodies would be another way in which they would feel part of the community.

The other recommendation for transition 4 is "to ensure that youth have the capacity to adapt and learn over their lifetime and to close the gap between work roles and education." Again, we're making the pitch here, the plea here, that the schools, colleges and universities become centres of lifelong learning.

I don't know what it's like for you, but for me I had one career. That's about it for my generation, and that's going to be it for me, I can tell you that. But most people in the next generation are probably going to switch jobs two or three times. As to my peers who did that, I thought they were nuts. They quit one and they're forced to do something else. It was like they were deviant. Not true now. My kids are probably going to have two or three different careers.

1620

As part of this we thought it would be important to have a new professional work role counsellor so that they could help students, from the beginning of high school, plan how they're going to go through the transition from high school into the workforce.

There are different stakeholders at that transition: the parents, the students and the business community. I don't think there's any example in Ontario where the three of them have come together at a community level and said: "What are we going to do about this? How are we going to help these young adults make the transition successfully between school and the workforce?"

The outcome for this transition? Well, you can see these could be easily measured—not the only ones, but how many are graduating from high school and what happens to them in terms of employment and higher education.

Marilyn, we're going to move on to you here. We're almost finished.

Ms Knox: So what should be done? First of all, we're talking about adopting a goal of equitable outcomes for all kids. We're not saying we're trying to produce a master race here. What we are talking about is to have a suitable range of outcomes for similar groups. If you get kids in a lower socioeconomic level, they should have the same range of outcomes as other categories.

There are five key directions. First of all, we're talking about all kids. We're not talking about picking at-risk groups, and Dan already spoke to the rationale behind that. There's more we could talk to if that's an area of interest.

The second is we're talking about outcomes that you

can measure. It's the big gift, I think, that this report gives. In addition to a very simple framework, the four transitions that people can understand, it also says there are certain outcomes we're going to look for that are measurable, that we can look at at both a provincial and a community level.

The third is that we see the parents as being the prime person or persons who have responsibility for their kids but that the parents can hold the community accountable for appropriate programming to support what they do. No parents can do it by themselves; no school can do it by itself. It's a partnership.

The fourth is we're talking about a focus on determinants, that is, really looking at the things that influence healthy child development.

Finally, we're talking about the fact that the province is an enabler. We really see that the communities are the locus where things will change but that the government can help, and in some ways the government can get out of the way to allow communities to do the things that need to be done.

Moving to action, the last and ninth recommendation—and we thought we'd be bold enough to add one more, that is, the report card—we've already spoken to the fact that the first Ontario report card we're recommending be actually done by the Premier's Council in order to show people what we're talking about.

It needs to look specifically at outcomes, it needs to be a help in measuring how kids are doing at the community level and it needs to look at key environmental indicators. It will help communities decide priorities. For example, in one community you may find that the indicators around children being born are really unacceptable, and that may be a place to start, or those indicators are fine, kids are doing well as they get into school, but something happens at the adolescent phase, so another community may choose to start at a very different point, which is fine. The report card can help set those priorities.

After that, it's something that we believe needs to be done at the community and provincial levels each year. Whose responsibility that is ultimately is yet to be decided, but we don't see government or a private sector group or anybody doing this by themselves; it's something that could be shared.

If we think about the next steps—and this is the last slide—first of all, we have done many community consultations. There are hundreds of people who have been involved in the development of this, two people in the room in addition to the ones behind us.

The youth report from the Coalition for Children and Youth was released at the end of March. We were amazed at the immediate media reaction on the spot, but then the huge coverage really that the report received. People are nervous when you start to say that things aren't fine for kids, and I think we can say things are not fine for all kids and it's not fine enough. That report was the first step in sort of sounding the alarm bell.

The second is today, the report that is out.

The next phase in our work is community mobilization. If I can be so bold, this is probably the very first step in

community mobilization, talking with you. Next Monday we're doing a round table with a handpicked group of people to give us some advice on community mobilization.

I believe the Premier called for all the MPPs to think about taking the report back to their communities and having conversations. We will be planning a very targeted program for the next 18 months to get people talking about a reorientation in this Ontario society towards a higher priority for children and youth.

The final phase, of course, is the report card.

That's what we really wanted to say. Dan, do you want to wrap it up?

Dr Offord: I think that's great. Nope.

Ms Knox: Then we can turn it back over to you. We've already had some back and forth.

The Chair: Thank you. We can call back some slides if that seems useful as we go through the questions and answers. I'll just say to committee members we'll be fairly flexible because I know different people are going to have questions on different parts of it. Why don't we begin with Mr Hope.

Mr Randy R. Hope (Chatham-Kent): I thank you for the presentation. As I reflected on some of the things that you've been saying, a lot of initiatives we've already tried in our community, and you said for phase 2.

While the presentation was going on, I wrote Tom a note and said your first phase would be right in Kent county; and I've already written the list of people who would be involved in a conference dealing with our youth. We had a very unfortunate situation in our community and now it's time to tap that energy and to promote it in a positive way to work with substantial problems we have in our community and try to help people in our community. It was a very unfortunate situation.

One of the problems I've discovered—we're doing one on the economic renewal in our community and we tried to blend the social justice issue along with economics and jobs. We're working on that. But one of the problems we discovered and you talk about—and I notice you were very careful in the words "the province getting out of the way"—is dealing with some of these models to deal with the communities, how funding is provided from government to these agencies in order to do these jobs.

I just wonder about some of the recommendations. I mean, we've got turf protection out there too. We have a number of children's services councils, youth services, out in our communities. How do we get down those walls and how do we tell the province to get out? I have my own ideas, but I would like to hear maybe some of the ideas that have been brought forward.

Ms Knox: When we first presented the report at the end of February to the Premier's Council itself, we had intense discussion about this and concern about turf. You just have to look at what's happening strictly on the health care side, let alone involving all the other sectors that we're talking about, to realize it's difficult.

We also have been working closely with the Royal Commission on Learning, because what they're about to

recommend at the end of the year is inextricably linked with some of the things that we're talking about. So we're hoping that a momentum starts, to begin with.

When we presented the work to the Premier's Council, there was some idea that maybe we should be getting a couple of communities that are particularly ready for action and try and uncouple some of the binding legislation that stops people from being able to try innovative things at the local level; unleash them to have envelopes of money so that they can actually move the barriers around. That was one of the ideas that came up.

Mr Hope: I looked at the children's services council, I looked at schools, I looked at day care, a number of groups. You talk about youth and interest groups. I have a group called HOBY, a leadership group, which is very active young people in our high schools, a very energetic public health unit.

You've got some who receive 100% funding, some who receive 80% funding, some who don't receive funding. You talk about communities being ready. I think communities are ready and I think some of the mechanisms of funding have to be lifted in order for the communities to be flexible.

Ms Knox: You bet. Yes.

Dr Offord: I would just add to that. I think your point's a very good one. I think there are a couple of issues. One is, as you know, there are two major groups of services for kids. There's specialized mental health social services, CAS; they're specialized and targeted. There's a whole group of resources which go into what we call mainline services: schools, recreation, public health. I think we have to have models where these two groups of services are brought together, because they act as if they're in separate worlds.

The second point is that within the specialized mental health social services, as you know, you've got children's aid and you've got specialized mental health services and special classes. Now, where a kid gets into this system is really due to luck and where he or she lives. They take the same kinds of kids, by and large. One can think of ways in which that sector could be improved by having a common intake system and common evaluation and stuff like that. There's a lot of work to be done. I think what we need are models of different ways in which that could be done.

1630

I think also it'll be important to keep score. Nobody likes to keep score in the adjustment of kids and the life quality of kids. If you keep score, I think it allows for feedback. Let me give you one example. If you kept score on recreation, you'd say, yes, recreation's great in this community. It serves kids who have everything going for them. That's what it does. It doesn't serve kids who are at risk at all.

Now, my guess is that's the way it is in most communities in Ontario. We have good data in some communities. If that's true, then that's the challenge to recreation. It's not enough any more to say, "We're going to be satisfied by the kids who come out." You say, "No, no, your duty is to serve a population of kids." So it alters

the whole thing around. I can't, from my own point of view, emphasize enough the importance of keeping score and finding out how we're doing.

Ms Knox: I think there's some will around making that happen. If you talk to the commissioners of parks and recreation, for example, there is an interest in supplying services to all kinds of kids. I spoke with the commissioner for North York, who's new there, and said, "What are you doing to involve kids in planning the programs?" It's one of the recommendations the Ontario Coalition for Children and Youth gave us: "If you're planning programs for us, involve us in it."

It may well be, with program planning on the recreation side, that if we involve youth more in thinking through what we do—the timing, the requirements, the particular activities that are being made available, the money, all of those things—truly we may find that it's money better spent and we may be able to set up programming that is appealing to a broader range of kids than we are at the moment. We're spending a lot of money on recreation programs already, so are we getting the best bang for the buck?

Mrs Yvonne O'Neill (Ottawa-Rideau): There's quite a bit here that I would like to ask about. I think one of your concluding remarks twiggged a nerve with me. You said that people become very nervous when they think that things are not as perfect as they felt they might be in children's services. I meet with quite a few people in that condition. Do you feel that this condition is growing? Do you feel that there is a feeling that children's services don't have the profile they did?

We certainly have seen cutbacks in these areas, and some of them are pretty obvious. I guess what I'm asking is, do you think the situation is changing or do you think it's just because people are more aware? What would be your answer to helping me understand more what you were saying? That's my first question.

Ms Knox: Maybe I'll start. Part of it is we don't know well enough what the answer to that question is, but we do know there's more children living in poverty. We know that the suicide rate has tripled in the last 30 years. We know that violence is on the upswing in some areas. We know that dropout rates from high school are not acceptable. We know that functional illiteracy rates are, by some thinking, up to 20%. Some of it says we're probably going downhill and some of it says, regardless of if we're going downhill or not, it's not acceptable.

Dr Offord: We don't know. I think the anecdotal answer is that the people on the front lines feel overwhelmed. Children's services are just worn out. For myself, I could see kids seven days a week, 24 hours a day. The fact is, there are more and more and more.

I think the difficulty is that the pressure is on what I would call these treatment resources to solve the problem, and that won't work. It will not work. Whether you have more money or not, it won't work, because the problem's too big. I think one has to back up and say: "Okay, we're going to need good treatment services, but it's going to have to be for a smaller group of kids. The group we have now is just too big." What we need now are programs at different levels. I think one of the strengths of

this report is it backs up a bit and says, "What could we do for all kids?" These are some of the recommendations.

Now, that won't do everything for every kid, but our hope is, and there's some beginning evidence to suggest, that if these recommendations were in place, it would help a lot of kids. Then, I would think, there will still be some kids who will need specialized services, but it will be a much more manageable number. So children's aid case loads would be down, children's mental health centres' case loads would be more manageable, then it becomes more doable.

The way it is now, with no overriding push on programs for populations of kids, the treatment sector is trying to pick up the slack, and I think it is overwhelming.

Mrs O'Neill: I'm very pleased you've brought parents in an awful lot, even your first recommendation. Maybe you've met parents. Are they expressing needs to you themselves? The youth, I know—I've had the same kind of meetings—are suggesting that parenting skills need to be improved. What about the parents? Will they come on board, do you feel, with this?

Dr Offord: A lot of parents clearly want and are willing to accept other support, whether it be parent training or community support. Trying to raise a kid, particularly if you're a single parent, rich or poor, if you're isolated with no social supports, becomes a very, very tough job, so there have to be ways at a community level to provide these parents with social supports.

Having said all that, there's a challenge. For instance, parent training programs work, if the parents will come. They don't do everything for parents, they're not cure-alls, but it helps parents manage their kids. It doesn't help parents with wounds from their own childhood, it doesn't help parents with lots of stress, but it does some things. The challenge will be to see how we can get high-risk parents out to these courses. The parents you want most to come out to these courses are the hardest to bring out. There's a lot of work to be done as to how to involve parents, particularly those who need these outside supports the most.

Ms Knox: It perhaps is an opportunity for a workplace to get involved. If employers understood how important it was for their employees who have families to function well, what it does is allow them to manage their work and family lives better. If you think about what it would take, maybe over lunch hours or before or after work, for it to be one of the places you could deliver such a program, it's a very simple idea. It isn't a very expensive idea, and in the long run it may be more supportive than other ideas that come into play. It's a small one, but it may be one that makes quite a difference.

Mrs O'Neill: I think it's very important, and I'm very pleased you said it. I have some very small experience that the business community is very interested in this issue.

You mentioned something, Dr Offord—or maybe you didn't mention it; it was more implied—that I had some difficulty with. I have been meeting with children's aid

societies quite often lately because they feel so threatened; I think that's one of the reasons they're coming. You kind of—what should I say?—lump them in with children's mental health services. They have a lot of difficulty with that. You likely know that. They see themselves much more in a protection role, and they feel that somehow or other there are several people trying to mould them into another function that isn't really mandated to them. I wondered if you could comment on that.

Dr Offord: Well, you're going to get more than one view on this. This is a controversial view. There is one community in Ontario where children's aid and children's mental health are coming together as one organization.

Here are the facts from our own work. What distinguishes the kids who come to children's aid over kids who come to children's mental health services is the fact that they are poor. Children's aid services in Ontario service poor kids, primarily. These kids have a lot of problems. And what service you go depends on where you live. When I last looked at the data—they're old—in Kenora 14% of the kids in Kenora go to children's aid society. Why? Because there wasn't anything else up there at that time; that was the only place to go. In Peel county, which was, relatively speaking, highly serviced, less than 1% went.

My own feeling would be that it can't be done overnight and all that sort of stuff, but as a first thing, children's aid and children's mental health should get together and have common intake procedures so we know what kids are going to what. My own feeling would be that it would be the same kinds of kids who are going to both services; it just depends on where you live. They do have different mandates to some extent, and that would have to be taken into consideration, but I think it's by luck and where you live that determines where you get into the system. If you're very poor in Hamilton, you go to children's aid; if you've got more money, you go to children's mental health. It's the same group of kids.

The Chair: Can you identify the community that is trying to come together?

Dr Offord: This is by word of mouth, so I hope this is correct. I'm sure it's Leeds-Grenville, that group up around Kingston. There are six counties there. They have come together, and as I understand it, they are working on or are going to have one joint children's aid and children's mental health.

1640

Mrs O'Neill: I've had the opportunity this year, just in the last few months, to have more contact with the north and what they're doing, particularly in children's mental health. They really do believe things can be predicted very early. I guess it's because people who live in the north tend to stay, and some of them have worked with and seen children actually from prenatal and now they see them in the courtroom as young offenders; they're often called throughout that time. They can actually name names of families and children they could have foreseen. Do you get that same feeling, that we can learn something from the north in that respect?

Dr Offord: I think you can, but I'm putting in a word

of caution about prediction. We're not that good at it. That's the overall answer. People can give individual cases: "I knew that kid when he was four. I knew he'd be in difficulty, and here he is." But there are other sides to that. A lot of kids like him at four are not in difficulty at 15, and a lot of kids in difficulty at 15 weren't in difficulty at four. When kids are in difficulty at four, we should intervene because some of them are going to grow up to be that way, but we're not going to be that accurate at predicting in the long haul. That's why I think there should be interventions at different points.

Mrs O'Neill: You still talk about early intervention, though?

Dr Offord: Absolutely, but not the only thing one would do.

The Chair: We're going to move on. Everyone wants to ask some questions, and we'll make sure everyone has time.

This is an excellent opportunity to look specifically at this report. We have talked with representatives, who are sitting in the room, from the Coalition for Children and Youth, and I just want to say to members of the committee that we are in the process of working out a specific time for them during our children at risk, just so we can effectively complete this part. While this is done under a different legislative section, it really all fits as part of the whole. As we move on, we will have an opportunity to speak directly with the youth who prepared that specific report.

Mr Tony Martin (Sault Ste Marie): Thank you for coming today. I came to this meeting from chairing a minister's working group on violence in schools, which is a big issue. One of the things you've mentioned here in a couple of places is the issue of kids feeling safe. I've got a couple of questions out of that work, because we've done an awful pile of it over the last number of months, trying to get a handle on this thing and put some things in place that will be effective and helpful.

You put here the "perception" of increased violence. Is it really simply a perception or is there increased violence out there?

Dr Offord: I don't think we know for sure. To know whether there is increased violence, you'd have to have good measures, of whatever it is you want to measure, at three points in time to know how things are going. The feeling of people is that there is increased violence, if you talk to child care workers and teachers etc. One would have to take a firm look at the same kind of data collected at three points in time to make sure those anecdotal, clinical observations are indeed real. You'd find out about youth arrests and stuff. I'll give you one example in the States.

In the United States, kids in 1993 report the same amount of anti-social behaviour as they did 10 years ago—they themselves. What's clear in the United States is that official statistics for youth crime show a tremendous rise in violence. Youth are reporting the same amount of stuff they've always reported, but it appears to be much more serious now.

To say that youth violence is getting worse—I don't

know the answer to that. Maybe it is known by data in Ontario.

Mr Jackson: How is it in your own practice, for example? How long have you been in practice?

Dr Offord: A long time, 30-some years.

Mr Jackson: Have you seen an increase in violent or anti-social behaviour in your cases? I thought that was the case.

Dr Offord: I think it is, you see, but what I say I don't think is a good example of what the deal is. It's not just who comes to me. The issue is on a broader scale. One of the things that should be looked at, and perhaps the data are available, is to say whether indeed violence is rising. Maybe it is rising, and if it is, then you could say, "Look, we collected data in 1980, 1987 and 1994, and by gosh," in whatever it is, youth expulsions from schools or youth violence, "things are getting worse." Just make sure that those data are available and firm before one makes the statement that it's getting worse by a certain amount. I'm just being cautious.

Mr Martin: Certainly we're trying to put in place some mechanism of reporting so that we can get some numbers and have some hard data on that.

Dr Offord: Our report card will be very valuable in that respect.

Mr Martin: When I look at this, it certainly looks good and I want to go out and do some of this and make it happen, but it's not as simple as that. It's actually quite complicated.

Another discussion we had today at the table that I chaired was the question of defining what parenting skills really are. Today, with the family being constituted differently in various circumstances and the different cultural groups we have in Ontario and all of that, how do we get a handle on all that? Did you do any looking into the impact of that on some of this information and how that interfaces, that kind of thing?

Dr Offord: I'll just say, and maybe Marilyn has something to add, that we're not very good at it. Our group runs parenting courses. These parenting courses probably do better with white, middle-class people. In some of those schools we did research in, there are 63 languages spoken. This is a whole new Canada and Ontario, compared to when I grew up in Ottawa. The parents have different ideas about parenting than I'm used to, and what is needed to help them with parenting is probably going to be very different from the kinds of things that would help people I grew up with.

One of the strengths of Ontario is our cultural diversity. One of the challenges is to think of ways of making these recommendations applicable to the wide diversity that's present in Ontario, not just the native community, which is a huge challenge, but other cultural groups. I would think we just don't know much about that yet.

Mr Martin: I'm not sure how I'm going to put this, but it's the issue of seeing more kids coming out of poorer situations who find themselves in difficulty. I did a bit of work with young people before I got here, and that wasn't necessarily the case. I dealt with kids from all levels. How does that really shake out? Why would that

be the case for me, given that you've said very clearly here that one of the determinants of health is prosperity?

Another question: We're seeing a phenomenon out there today of young people going to welfare, and there's the penchant to say that the great majority of them really shouldn't be there. There's a huge backlash and there's a huge effort now to try to catch the ones who are in fact abusing the system. Do you have any thoughts on that, given that we're looking for resources to put into the kind of thing that you're suggesting here?

Dr Offord: You're raising large questions. The first one is an important question. Poor kids are at increased risk for everything I don't want my kid to have, and I'm sure you don't want your kids to have, by two or three times. But at a population level, most of the kids who have these things are not poor, because the poor are such a small segment overall. If you could eliminate all the serious anti-social behaviour emanating from kids among the poor, you'd make a reduction in the overall problem. I don't know what the exact figure would be; my guess is that it would be no more than 20%.

Most of the problems that afflict kids in Ontario occur in other than the poor, because there are a lot more kids. The poor have more of them. You've got to think of solutions and not say, "If we could only get it straightened out with the poor, we'd be in great shape." The fact is that we will not. It will not attack the major numbers of kids who have problems. That's number one.

The second thing is that we've finished a piece of work that we're going to have out shortly. If you look at unemployed 20- to 24-year-olds in this province, you find that by and large they're a healthy group of young adults. The difficulty appears to be that there are not jobs for them. They're not a disadvantaged group overall; there are some within them who are disadvantaged. If you contrast that with school dropouts, however, kids who drop out of high school before graduating, you find that these kids are a very disadvantaged group, and it's not just educationally. They have a lot of difficulties before they ever drop out. They have much higher rates of psychiatric impairment.

The implication of that latter finding is that if you want to do something for dropouts, it's not just an educational problem. We're going to have to find ways of delivering a wide range of services for these kids and deliver them in such a way that these services are acceptable to these kids. In our work we found a big difference between high school dropouts, the disadvantaged group and all sorts of sectors, versus the unemployed young adult, who generally tends to be rather healthy compared to his peers.

1650

The Chair: Mr Jackson, I understand that we may have a bit of a time problem, because you have to go and do some interviews on the report. So if you would go ahead, I will do my utmost to get those who are remaining on as well, just so members are aware.

Mr Jackson: I would like to thank the co-chairs for being available today and for being so concise in your responses. It's appreciated. I don't always agree, in

particular with Dan. We've been before each other three or four times in various committees around social policy and children.

Let me say at the outset that I had hoped the report would have focused in on the tripartite nature of how this province deals with children. I facetiously felt that the title *Yours, Mine and Ours* was the Ministry of Health, the Ministry of Comsoc and the Ministry of Education and that "*Yours*" was generally the plight in Health, "*Mine*" was generally always the claim in Community and Social Services and "*Ours*" was this sort of split personality between our public and separate boards over each child in this province.

Underlying that subtle humour is a very serious concern. I can think of no other fine-point example than how we're handling preschool speech-language pathology in this province at the moment, which in my view is tragic. We've got millions for third-language instruction, but we can't teach a child to communicate in the first working basic language of the school yard. I don't indict the report; I just had more hope placed in it that it would have zeroed in on that. You may want to respond to that. That's my own personal view and I think that's really the tough nut for us to get at, just as we've had to deal with that at the other end of life's schematic, with long-term care, for example. We really must deal with this issue.

The second thing I wanted to raise for your consideration is that the transition to school is a critical issue. People have said that we have a fine educational system, and we do. We have one of the most expensive educational systems in the world and therefore we should be able to get better results, in human terms, out of our educational system than we're getting.

I guess my fear is that your recommendations—there are only two of them. One of them—forgive me for saying this—smacks of basically a labour agenda, that somehow, if you read it very carefully, we're talking about parenting and children and then we're talking about workplace policies, friendly policies in the workplace, flexible hours, flex-time options, sick leave to care for sick children, extended parental leave, top-up leave provisions, options for part-time work, work at home. These are all labour issues; I'm sorry, but they are.

I've never quite seen a report flag that in such clear and concise terms. If we look at the 1.3 million on social assistance in this province and the million-plus who are unemployed, if we really want to get at the nub of a large, disproportionate percentage of children at risk, their challenge isn't who makes the box lunch and gets Johnny out to the bus to get to school while mommy and daddy go off to work. This is not the atypical at-risk situation in this province. We're looking at probably—the numbers in March came out—a quarter of a million children from single-parent families who are under the age of 10. Then also we have 375,000 children of single parents on social assistance. These are the largest cohort we've seen in our province's history and almost disproportionate with provinces like Newfoundland and others where chronic unemployment and serious problems have become more accepted than we should be allowing them to be in our province.

Again, you may want to comment on that, but when we were looking at a priority for social service reforms to ensure that a child has a guaranteed access to an economic envelope of opportunity, recently we've had some policy announcements that this just is not doable.

Yet your report mentions nothing of it. Again, that causes me some concern. There's some very good stuff in here, but if I were looking for the big issues to crack some of the toughest things out there, those two I was looking for, and I didn't see them. Perhaps you could tell me why.

Interjection.

Mr Jackson: I've been waiting for the parliamentary assistant to Comsoc to make some contribution to this.

Ms Knox: What we did was we looked at what the determinants of health would be for children entering school, and as we talked about what the determinants were that you could take action on, you could measure, you could do something about, that were amenable to policy change, high quality care and prevention of injury were the two that came to the top of the list. They're not the only two, but if you look at interventions on those two, high quality care and prevention of injury, these are the recommendations that fit up against those.

You may dispute the choice of those determinants, but if you're picking those determinants, those are the ones that make a difference, and if you look at entry into school, sort of prior to getting into school, there are issues around school that we need to deal with. I think if you look at the transition stage 3, it speaks to that more, some of the issues that you're raising.

We felt that at the local level was where there was the need to bring the pieces together, and it absolutely doesn't duck the need that Health, Community and Social Services and Education have to come together, and if we look at a community where we start to change things and we get the government to unbundle some of the funding and look at envelopes, the opportunity will be at the community level to do exactly what you're talking about.

Our thought was not to be so prescriptive as to say who has the lead and what each community must do, but to give them the framework and the measures so that they can figure out what to do.

Mr Jackson: Marilyn, you hardly even say that in the report. I wouldn't expect you to pick the lead ministry.

Ms Knox: We said all of those things in the report. Tell me why you don't think so. I'd be glad to hear it.

Mr Jackson: I suspect that the courage in any report is in its recommendations, and it was in that area that I was looking for something a little more substantive or some insights with respect to differentiated entry points.

It's very easy. We're talking to a child psychiatrist who's dealing with two- and three- and four-year-olds. In the educational sector we know that approximately 60% of the cognitive development of a child is occurring between the age of birth—pre-birth, depending on the report—to the age of six, and yet not to have had this whole area of entry into schools thought out in something a little more beyond, "If there's sensitivity by your employer, whomever you're employer might be, that we

believe there is room for improved parenting"—there are too many children in Ontario who don't have parenting, or that the social assistance and simple survival within it has created problems for children, and as the doctor has referred to, we've even got them ghettoized in terms of identification if we look at certain housing projects in Toronto.

That was my comment. I'll re-read the report, but like all persons in the interests of a brief presentation, I went immediately to your recommendations section—

Ms Knox: It doesn't live for you.

Mr Jackson: I could've written eight or 10, and I'm sure you would've liked to have written eight or 10, but for some reason the symmetry was to have just a couple in each of those levels. It's your report.

Finally, and I have to yield the time because the Chair is being most patient with me, perhaps, doctor, if you'd look at whether it's young offenders' statistics in this province or incidence reports by police, you will see just how serious our violence problem is and the nature of the violence, whether it's in our schools or just in the youth cohort, but I was concerned that you felt that it wasn't quantifiable enough to be able to make a statement that we are living in a more tolerant-of-violence society or we're in a more violent society than we were 10—or whatever other two points you wanted to examine.

Dr Offord: Maybe the data are available; I simply don't know, but I think it's important to find out. If the data are available, some conclusion could be said about that.

1700

Mr Jackson: It didn't come up in your report that much, is what you're saying.

Dr Offord: I don't understand your point. Is your first point that we didn't talk about the lack of coordination among ministries? I just want to understand it. In just plain English, what's your first point?

Mr Jackson: My concern was that I was somehow hoping that you would, either in the recommendations section or in the report, identify in clearer language your concern for the various ministries that have almost competing interests.

Dr Offord: Got you.

Mr Jackson: Your response to Ms O'Neill's question about the role of children's aid societies might have caused me even more concern, because I see that as more the only legal protection a child has in society through that piece of legislation is our children's aid societies, and that frightens me even more.

Unless the Chair will allow us to get into a debate, I was quite concerned about those responses.

Dr Offord: Let me try and answer that question.

The Chair: If I could, it's just that I have a couple of others who want to ask questions. I appreciate you're getting close to a bit of a time problem. I wonder if you could just reply to that, and then I would like to try to at least get in one more questioner before we have to leave.

Dr Offord: I think we clearly understand that ministries have to work cooperatively together, if that's the

issue. What we did in the report, I think, is a wise thing. This report is not directed only at government—it is not—and the wellbeing of kids in Ontario will not be solved by government alone, believe me. It will be solved by communities outside of government.

Now, our recommendation for the preschool I think should be in line with you. We feel that kids should have a stable and supportive relationship in the first five years of life if they're going to do well in grade 1. That is a recommendation. How that's to be brought about and bring the different sectors together to do that—one can try and do it at a provincial level. We are going to try and see if there are models in communities, as Mr Hope mentioned earlier on, that can bring those services together.

Your second point about poverty I didn't understand: that the way to help poor kids is what, to give the parents employment? I wasn't quite clear what your point was.

Mr Jackson: Some of the social assistance reform that was targeted for children was recently shelved by the government. I just didn't want to get into a political statement, but obviously it wasn't discussed at your committee.

Dr Offord: But just let me tell you the point there. I think it's clear that there two ways to help poor kids. It's an open question. I'm all for ways that make things easier for the parents. Also, another way to help poor kids is to make sure that they have equal access and benefit equally from programs that are available for all kids. In both cases, I think we're deficient in the province.

Mr O'Connor: I appreciate your report and the thought put into it, and I appreciate your coming before this committee. At times we do get carrying on a wee bit, because we'd like to see more in here, you know, and we know that you've had to focus on just some.

Something that wasn't talked about, again, very much in this report, and I just wondered if you can explain perhaps why or how it could have fit in as part of the report card mechanism, is violence at home, violence that's in a community. We talk about community involvement and the transition to work and community and everything else, and I think we've got a problem there as well. We've got a lot of hidden problems, and you've mentioned in your opening that family violence is out and it's open now; it's not hidden any more. But I don't think we've dealt with it, and I don't think you have, but I wondered if maybe you can explain why and if there is room for that to fit into the report card.

Dr Offord: Clearly, there's room for it on the report card. The problem with it is that we're going to have to find a way of getting measurement of it that appears to be fairly reliable. I would agree that that's an important issue and some of the interventions that will happen in these communities—if we knew what to do to prevent that and knew how to measure it, it would help us a lot. I agree with you. It's an important issue, and in the next stage we're going to have to figure how one might both deal with it and measure the outcome.

Mr O'Connor: I was in Guelph on Friday. The Ontario Farm Women's Network pulled together people

from the rural communities to talk about this type of violence and what not, and it is something that's difficult to deal with.

One of the recommendations, your slide 30, talked about the mentoring in all secondary schools. Would you expand on that for me? My riding is rural, and I also have a native community within my riding, and I know that other parts of both Durham region and York region have a higher ethnic makeup and diversity. I wondered if you wanted to touch on that. Would it be targeted, or not targeted? How do you approach it?

Dr Offord: I want to get back to your first question and comment in a minute. My own feeling would be not to target it, not to say: "Listen, you don't need a mentor, but I want you to get a mentor." That probably does adolescents more harm than good, if you stigmatize or label them.

I think it would be open to all. The point you raise is that it would have to be done in a culturally sensitive way, that the mentor would have to be seen as suitable by the person to be mentored.

Also, the score would be kept at the population level—very important. What will happen with any mentoring program is that the kids who need it the least will be the first ones to pick it up and the volunteers will be the first to pick them up. What needs to be done is to find a way to find out: "Who does not have mentors? And what particular things do we have to do to make sure that these kids who appear to be most in need of mentors are likely to get them?" That's the importance of keeping score at the population level.

You had one other point about reducing violence. One of the things we know works in preventing child abuse—we don't know much about how to prevent things, but if you take young single moms and you provide them with a telephone and a trained home visitor on a regular basis—it could be a public health nurse, it can be a trained home visitor—there are data to indicate, of very strong scientific design, that these parents do better and their kids do better. Whether it does everything for these parents and how much better off the kids will be over the long haul, we don't know. But I think we have some leads one could put in place at the community level to try to cut down, at least to try to prevent, early severe child maltreatment.

The Chair: I think we've worked out an arrangement that will ensure that Ms Carter and Mr Rizzo get to ask their questions, but Marilyn Knox has to leave right now. I believe Dan Offord can stay for a few minutes. I thank you for coming to the committee today, and we'll complete the questioning to Dr Offord.

Ms Knox: Could I say one or two things before I go? First of all, this is the report available from the Premier's Council on Health, Wellbeing and Social Justice. What encourages us from the conversation we've had here today is that we were right to be bold enough in phase 1 to get the conversation going. We were also right not to think that we had it all figured out by the end of the first phase. It's important for the community mobilization to be a piece of what each and every one of us around this table does, and if you believe there's more to this than

we've gotten to, then it's Yours, Mine and Ours.

It perhaps is something that needs to go beyond political agenda, although the politicians are absolutely fundamental to this. As Mr Hope pointed out and Mr Jackson pointed out, you all have very strong views and experience in your own areas and you know what's going to start to open things up. We don't know. It's why we didn't overprescribe in this.

We very much appreciate the interest and the very engaging conversation. What I can say is, every time we have this conversation, from the group of seven paediatricians I spoke with in great detail on Saturday morning, to this group, to the coalition's conversations and so on, every single time the conversation is most engaged, most concerned, sometimes at cross-purposes, but always in the long run trying to do something, that now is a time that we can't ignore this. We appreciate the interest and the fact that you put us on the agenda just like that.

The community mobilization has now begun. It's a good test for us to know that we need to go out and get more input. Perhaps there will even be another report that comes in at the end of that phase. Thank you very much.

1710

The Chair: Thank you very much. We'll now complete the questioning. In the interests of time, Mr Rizzo and Ms Carter, perhaps you could encompass it in one question.

Mr Tony Rizzo (Oakwood): Just a couple of words. You are talking about families changing. I wonder if you considered the new family of the future. People are talking about the same-sex family and what the implications are going to be for the children in the future.

Dr Offord: I don't know. The only thing I can say is that the Ontario I grew up in wasn't like it is now, and it's changing in many ways. That's one way. Cultural diversity is another huge way. One is going to have to be open and not feel one knows too much. I don't know what will happen there. "Humble" is what I was trying to think of. I just don't know.

Ms Jenny Carter (Peterborough): This is such an enormous subject, it's hard to know which thing to raise, especially in limited time.

I think we're at a point now where changes that have been happening over a long period have come to a crisis, with more and more moms going out to work. In the old days, moms had to stay home because there was so much to do in a household, and now we've got all this automation and ready-made food and so on. It's evident that it's better for women that they can get out, but it's not so evident that it's good for children, so we have this problem.

Do you think the main emphasis should be on having universal day care so that women can just go out like that and forget about it, or should it be more the kind of thing I think they're doing in Scandinavia, where you give very long parental leaves and allow both parents to have quite a long time off with some kind of pay?

Dr Offord: Again I don't have all the answers. The one thing that's clear is that the mother has to feel comfortable with the arrangements. That appears to be a

big predictor. Some mothers feel comfortable going right back to work; some mothers feel comfortable taking the six months off or whatever it is.

I don't think it's either/or universal daycare; there has to be a way in communities to make sure that whatever the working arrangements are of the parents, the kids have a stable and stimulating environment. That can be in day care, it can be in preschool resource centres or it can be in a variety of ways. But all of us have to understand that for the future of the country, we have to find ways of looking after these preschoolers in a consistent, stable and stimulating way.

Ms Carter: Absolutely, and I think you're right that the mother has to have that choice.

Another thing concerns me. When we look at aboriginal societies, we say a lot of the problems they're experiencing are because they almost lost their culture and they don't know where they are in the world and they have to get that back. Do you think a similar thing is happening with the rest of us, that kids are too liable to grow up without really being involved in any heritage, partly because we have so many different ones coming together that it's hard to maintain any given one and we're left with something that's kind of a mishmash and a bit thin?

Yesterday, I went to a Mother's Day concert at the art gallery. It was young musicians, who were superb. They all seemed to be children of immigrants, for some reason. I thought, "I'm sure none of these kids is going to get into crime or drugs or anything, because they're just too involved in something."

Dr Offord: I think you've hit on a very important point. Clearly, the cultural roots that people have and that kids have are important.

One of the findings from the youth report was the tremendous amount of racism these kids experience. This is a thing that's not going to be solved by government, for sure. How the heck are we going to raise a generation of kids who are going to be tolerant and respectful of a huge diversity of ethnic and cultural and racial backgrounds? When I was growing up in Ottawa, it was Anglo-Saxon and that was it, and a few other people we thought were odd. It's very different now, and we're going to have to think, all of us, of how we can help raise kids who are tolerant of these differences.

My own experience as a clinician coming in again: This is a huge problem, a huge problem in the schools, and how that's to be solved—all I know is that that kind of stuff starts early on, and we're going to have interventions throughout the life cycle.

Ms Carter: I think it's important for kids to have their own culture, not just to be tolerant of other people's. Some of them just don't.

Dr Offord: I agree with you on that point.

The Chair: We could go on, but I know you have to head off. I want to thank you and thank Marilyn Knox again for coming before the committee.

There are a number of issues we haven't been able to get into, not the least of which is thinking through the community report card and how that will evolve. I

understand from your remarks that that is something the council is going to turn to next. As a committee, we may at some appropriate time in the future want to sit down and have a look with you at what has evolved, because clearly that's going to become a very important element of the work you've described.

In closing, I would like to thank you all on behalf of the standing committee. This has been very helpful to us and also for those who have had, and will have, because

of the way these things replay, the opportunity of watching the hearings on television.

Over the course of the next few weeks we are going to be looking at the question of children at risk and talking with some different provincial groups and others about that issue. Everything you have placed before us today fits in very well as a kind of an appetizer, in more ways than one, to what we are about to do.

The committee adjourned at 1717.

CONTENTS

Monday 9 May 1994

Premier's Council on Health, Wellbeing and Justice	S-1475
Marilyn Knox, co-chair, children and youth project steering committee	
Dr Dan Offord, co-chair, children and youth project steering committee	
Zenía Wadhvani, project coordinator, Ontario Coalition for Children and Youth	

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- ***Chair / Président:** Beer, Charles (York-Mackenzie L)
- ***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- *Carter, Jenny (Peterborough ND)
Cunningham, Dianne (London North/-Nord PC)
- *Hope, Randy R. (Chatham-Kent ND)
- *Martin, Tony (Sault Ste Marie ND)
McGuinty, Dalton (Ottawa South/-Sud L)
- *O'Connor, Larry (Durham-York ND)
- *O'Neill, Yvonne (Ottawa-Rideau L)
Owens, Stephen (Scarborough Centre ND)
- *Rizzo, Tony (Oakwood ND)
Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Also taking part / Autres participants et participantes:

Jackson, Cameron (Burlington South/-Sud PC)

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Gardner, Dr Bob, assistant director, Legislative Research Service



S-51

S-51

ISSN 1180-3274

**Legislative Assembly
of Ontario**

Third Session, 35th Parliament

**Assemblée législative
de l'Ontario**

Troisième session, 35^e législature

**Official Report
of Debates
(Hansard)**

Monday 16 May 1994

**Journal
des débats
(Hansard)**

Lundi 16 mai 1994

**Standing committee on
social development**

Children at risk

**Comité permanent des
affaires sociales**

Enfants en situation de risque



Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944 – 1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Monday 16 May 1994

Lundi 16 mai 1994

The committee met at 1628 in room 228.

CHILDREN AT RISK

Consideration of a matter designated pursuant to standing order 125 relating to children "at risk."

The Chair (Mr Charles Beer): Good afternoon, ladies and gentlemen. The standing committee on social development is in session, dealing with standing order 125, a designated matter referred to us regarding children at risk. I will read the charge to the committee:

"That the committee meet for a period of 12 hours to investigate protection of children, specifically those at risk. The hearings would focus on the population of children at risk, the services available to them and their families and recommendations to improve the continuum of services from preventive programs to agencies of last resort. By 'children at risk,' the committee means children in need of protection under the Child and Family Services Act, children affected by inadequate living conditions and child poverty and children suffering physical and sexual abuse."

Before we go to any opening comments members would like to make, and I'll call first on Ms O'Neill who brought this standing order 125 to the committee, I'll note that we will be hearing from the Ontario Coalition for Children and Youth and from Dr Louise Sas. We may also have to go up at various points to vote. They may work it out and have a stacked vote at 5:45, but at the moment we would be going up at 5 o'clock for a vote. With that, I turn to Ms O'Neill, if you would just start us off and set out the reasons for these hearings.

Mrs Yvonne O'Neill (Ottawa-Rideau): This set of hearings has been a long time in coming, it seems to me. I am very happy that we are to begin today.

It's often said that our children are our best hope for the future. Many of today's children, however, face challenges in their daily lives which put their future, and thus our future, at risk. More and more, we hear disturbing statistics: There are serious shortages of mental health services for children; one in six children in Ontario live in poverty; 40% of those who are part of the social assistance system are children; three quarters of the food given out by food banks in the greater Toronto area goes to families with children; suicide and homicide rates are three to four times higher for children living in poverty than children from high-income homes; child abuse continues to present itself as a serious social problem; last summer there were 10,000 homeless young people in Metro Toronto; wards of the children's aid society are found to experience significant delays in their progression

through their school life; finally, children who are environmentally disadvantaged in one sociodemographic area are at a great risk of being disadvantaged in another.

Although these disturbing facts go on and on, they have very limited official response. Efforts to help are often ad hoc, depend heavily on volunteers, and struggle to survive. Throughout 1993 and on into 1994, there have been significant cuts, and indeed goals continue to be presented that would decrease government funding to a wide variety of children's services. Because of these cutbacks, children's protection agencies such as children's aid societies and children's mental health centres have been forced to make very difficult choices which may further jeopardize the care and rehabilitation of children who are already in high-risk situations.

Many of Ontario's young people are living in desperate conditions. They cannot focus on their education or their prospects for the future. If you are homeless and young, you can't find a job because you don't have an address. You're often caught in a bewildering maze of inadequate services which you can't access because you are either too young or too old. You can't access training programs because the waiting lists are too long. And if you are a member of a minority, if you have a disability, if you are a refugee or indeed if you are a youth with AIDS, the "can't" list is even longer.

We as a province and as legislators must address these issues and we have chosen to do so by inviting people who are experts in this field to share with us their perception of the extent of the problem and to present possible short- and long-term solutions.

This is a complex problem and it won't be solved by a simplistic Band-Aid response. The solutions will only emerge from a coordinated approach which includes all of those with a stake in the healthy development of the next generation, and that means most of us, you and I.

Government cannot and should not be the sole decision-maker in terms of what those solutions must be. We must encourage children and youth—and today we're doing that—and their families and their community agencies, recreation and service clubs, schools and businesses, to work together in an integrated way to develop creative solutions to make lives better.

If I might quote from the report of the Premier's Council on Health, Wellbeing and Social Justice, Yours, Mine and Ours, just recently presented:

"We have designed most of our services to kick in when problems become apparent. We have mainly invested in crisis care or aftercare...this kind of interven-

tion is having little impact on improving the overall healthy development of the child and youth population of Ontario. It tends to stigmatize those who receive care. It is also very expensive."

As the report goes on to say, "Our society cannot afford to lose the generation growing up now or the children who will be born tomorrow. The prosperity and social stability of society depend on its ability to pass on to new generations the responsibilities of adulthood."

All children and youth must be valued for who they are now as well as who they will become as adults. Parents and those who take on parental responsibilities have the primary role in raising healthy children and youth. They must be supported by their communities in that role. I trust our work in this committee will complement their efforts.

Mr Cameron Jackson (Burlington South): I simply wish to state that my colleague Ms O'Neill has summed up, I believe on behalf of all committee members, our interest in and support for the time we will spend on this issue. I also understand that by yielding my time I will free up additional time for presentations that were unable to make our short list. So I endorse everything that has been said as an opening statement, which I believe could be embraced by all three political parties here, and I look forward to listening, learning and contributing to the process of reform in this critical area.

Mr Randy R. Hope (Chatham-Kent): As we look at the problem of children at risk, and I know a number of us through our own communities and in government try to deal with problems in our communities, it's important that we as legislators understand where community groups are coming from but also to reorganize ourselves from a community point of view in order to prevent having children at risk. I look forward, along with Mr Jackson, to listening to the people from the community. I thought it was a very good report from the Premier's Council, to try to address some issues dealing with children. I look forward to the presentations that will be made here today and to the 12 hours allotted to this process, to hear what the communities have to say and how we can take more proactive approaches in solving our problems instead of bickering about them.

ONTARIO COALITION FOR CHILDREN AND YOUTH

The Chair: With that, we'll call our first presenters, from the Ontario Coalition for Children and Youth. I just ask Mr Hope if members of the committee could have copies of that children's services document. It would be useful background.

Welcome to the committee. If you would be good enough to introduce yourselves not only to the committee members but also for the purposes of Hansard, please go ahead with your presentation. Let me say that we have an hour. We may get called away to vote at 5, we may not, but if the bells start ringing, don't take it personally. It just means we have to go up and vote and then we'll come back and continue with your presentation.

Ms Zenia Wadhvani: My name is Zenia Wadhvani and this is my assistant Chung Tang. We're both with the Ontario Coalition for Children and Youth, and we're here

to talk to you today about what we call the Young Voices Report. This was commissioned by the Premier's Council on Health, Wellbeing and Social Justice.

Mr Chung Tang: I thought I'd start by talking a little about the coalition. The coalition's mandate is to ensure that the voices of children and youth are heard by policymakers, a community development approach to build involvement from the bottom up, and youth led and supported by a number of individuals and organizations. The coalition is also committed to developing and supporting the leadership and participation skills of children and youth.

Our purpose is to empower children and youth to have a direct voice in decision-making on issues that concern and affect them, and to promote the rights of children and youth and their entitlement to healthy development as a matter of highest priority for public policies, programs and resources.

Ms Wadhvani: Basically, we went around Ontario to speak to children and youth about their issues and their concerns. We spoke to children as young as two years of age. How we classified "children" and "youth" is that those under the age of 12 were considered children and those 13 and above were considered youths.

When we were speaking to children, it was difficult to ask them, "What are your issues and what are your concerns?" so instead we asked them to illustrate for us their issues and concerns. So we asked them to draw what makes you happy, what makes you sad, what scares you, and we got a variety of responses and it worked very well for us. After their illustrations, we also discussed with them what they liked and what they didn't like, and we asked them questions like: "Suppose you were the genie from Aladdin. What one wish would you grant yourself or would you give to the world?" This made it really easy for us to talk to the children.

1640

When we spoke to youth; we had a little more formalized structure. We were in discussion groups, little rap sessions, and we asked them what their issues and concerns were, what they thought were possible recommendations for those issues, what they thought was the definition of a healthy child or youth and if they thought that children and youth needed to have their voices heard in the community and, if they did, how they should have their voices heard.

We had a total of 21 sessions and we tried to cover a diversity of children and youth as much as we could, so we spoke to children and youth of different races, of different socioeconomic status, different sexual orientations, disability and geographics.

Mr Tang: The issues that we covered included education, careers and employment, social relationships and health, racism and discrimination, violence, global perspective, housing, recreation and transportation. Now, within those issues, for example on the education system, children and youth talked about the need to diversify our curriculum in terms of addressing the achievements made by aboriginals, by different racial minorities and ethnic groups. They talked about the lack of understanding on

the teacher's part in terms of understanding their different races, in terms of understanding their ethnicity, their sexual orientation, varying religious backgrounds.

In terms of peer pressure, some of the children and youth talked about the pressures in doing drugs, alcohol, smoking, dressing to fit in, in terms of looking like you belong to a specific group.

In terms of recreational facilities, we talked to children and youth in the rural areas, such as Niagara Falls, and they talked about the need to have a community centre; that they just hang out in laundromats, on street corners.

In terms of transportation, we talked to children and youth with disabilities and they talked about the fact that, for example, school buses are not constructed to specifically meet their needs; therefore, when they actually have to sit in the buses it's very uncomfortable.

In terms of the education system, they talked about the fact that what they're learning at school is too theoretical, that they're not learning practical skills which will prepare them for the work world.

Ms Wadhvani: To give you an idea of some of the anecdotes that we heard from the mouths of babes, I personally heard from nine-year-old girls in the Islington area who told me about their fear of rape. I spoke to a group of 10- and 12-year-olds in Thunder Bay who expressed to me that they were all sexually active at that age, that they knew about condoms and sexual activity. When I asked them right after that whether they smoked, they looked at me like I had asked them the most stupid question in the world, because they said: "Of course. Everybody smokes. We all smoke."

Other things we heard were, for example, through illustrations, when we were asking some of the kids to draw for us what scared them. I had a young boy draw for me two stick figures—one was larger than the other—and the blurb above the smaller character read, "Please don't fight me." I didn't need to ask him anything more; I could see the fear within his eyes. He was experiencing it. This boy couldn't have been more than nine years old. I asked a young girl who was about seven about what she didn't like and what she liked, and when I asked her what she didn't like, she replied, "Myself," which gave me a very good indication about her self-esteem and possibly about the self-esteem and lack of confidence of a number of children and youth in Ontario today.

As a result of the report, we came up with four recommendations. The four main ones are, first, that we need to have a provincial network, a provincial conference for children and youth to come together to express their ideas so they may be able to communicate with each other and help each other. If they've got a provincial problem, they can work on it together. If they've got individual problems, perhaps they can help each other out in a peer mentorship program.

We also asked for a change within the education system, and that's everything from teacher training to the curriculum to the structure of the school.

We also asked that the media representation of children and youth be altered. Much of the time we find that when a child or youth is involved with something negative it's

plastered over the front page and given a lot of publicity, but when a child or youth tries to do something really positive, it's given a small column in another subsection of the paper, if it's given space at all.

Last, but most important, and this runs through the entire report and it was accentuated by everyone to whom we spoke, is that children and youth really need to have a say in those decision-making processes that affect them. That's at every level you can think of, whether it be within the community, within the home, within the education system or at the government level.

We made our presentation really short and concise to give you a brief overview because we realize that you probably have more specific questions that we would answer. That's where we'd like to leave it.

The Chair: Before starting the questions, how many of you in all from the coalition carried out the study?

Ms Wadhvani: Just Chung and myself.

The Chair: So you did that and then reported to—

Ms Wadhvani: A steering committee.

The Chair: How many people were on that?

Ms Wadhvani: About seven people on the steering committee, and then we have a larger coalition. We were letting them know what we were going on and doing.

The Chair: How did those young people become involved in the steering committee? Were these people from different parts of the province?

Mr Tang: They vary. They're from all over the province, some of whom helped us set up those workshops with the children and youth. A lot of this was volunteer work.

Mrs O'Neill: Thank you very much, Zenia and Chung. I would like to begin where you ended, with the provincial conference. Did you see much in the way of peer support systems, particularly for the youth, built into the school system, or did you find that there weren't avenues existing now for that?

Ms Wadhvani: We've heard that peer mentorship programs exist in some schools and they're beginning to exist in a lot more. We're also finding out that they're not necessarily working, because the peers doing the mentorship are high achievers and the cream of the crop who end up on the student councils. The youth experiencing a lot of difficulties with academics or problems at home can't relate to that person who's doing really well, because they just don't understand their problems. But we do know that peer mentorship works a lot better for a lot of youth than having an adult do it.

Mr Tang: I remember talking to children and youth who had disabilities, and they talked about the fact that even within the school system, not only are they not included but there isn't such a thing as peer support. They recommend that they have a buddy system whereby different students can learn more about their social realities and the barriers they face within the education system.

Mrs O'Neill: So you really do think that if it were organized on an annual basis, there would be a very good response to a provincial conference?

Ms Wadhvani: Yes.

Mrs O'Neill: I'd like to go to two other areas you mentioned, because I often have heard that housing has a great deal to do with a person's, particularly a young person's, success. Could you say a little more about what you heard about that?

Ms Wadhvani: When I spoke to a group of youth who are part of the youth in care, for them housing is a very big problem. They brought up three main A points, as I call them: One was affordability, one was accessibility, and one was attainability.

Even if they find housing that's affordable, it may not necessarily be acceptable. It may be in a deplorable condition. It's really hard to find housing. Affordability is a big problem, because they want to go to school but they have to work in order to afford their housing and their school and they find they're really caught within a catch-22 situation. They have to make a decision about whether school is a priority or their job is a priority, and much of the time they have to choose their work over school.

Mrs O'Neill: You talked about them having difficulties with the curriculum and that they would like to learn more practical skills. Did you learn a little about what those practical skills are that they wanted to have more input in or knowledge of?

Ms Wadhvani: It depends on the type of occupation they're trying to pursue. What they said, especially the university students, is that when they're getting out into the real work world, the theoretical knowledge they've learned isn't enough for them to practise with the hands-on skills they need. They're finding that either they have to return to college or have to do more volunteer work to gain some experience. They didn't go into specifics of what the school should teach, because it would really vary, depending on what they're going into.

1650

Mr Tang: Some youth said that the most simple, practical skill we need today is to learn how to use computers, word-processing applications, for example, WordPerfect. A lot of them don't even know how to use a computer. And in terms of simple interpersonal skills, it's how to deal with people in the workplace, how to look presentable, how to deliver presentations to clients, things of that nature.

Mrs O'Neill: They don't have that in the high schools?

Mr Tang: Not all high schools have that. When I was in the Niagara Falls region, they said they only have maybe one computer for every 20 kids and they have to take turns using it, and the stuff they do have in terms of hardware and software is all out of date. Their school does not spend enough money on it.

Mr Jackson: Thank you to both presenters for your insights. Forgive me for asking, what was the most disturbing piece of new information you picked up? You obviously went in with your minds open, but in the sum total of your life experience to date, what was the one thing that struck you and resonated with you that "This is something I wasn't prepared for"?

Ms Wadhvani: The anecdote I gave before about the young girl who, when I asked her what she didn't like,

said, "Me." That's something I'm never going to forget. That's has stuck in my mind the most in this whole report. It gave me a whole vision of the lack of self-confidence that exists. It's really low. This is a young girl who is seven years old who is telling me this. What kind of environment is she living in? What kind of school is not supporting her, or home environment?

And that wasn't the only example. There was another youth in high school who told me that one of his teachers had told him not to bother to apply for college or university because it would literally be a waste of his time and money as "He would fail anyway," and his vice-principal supported that. To hear that is—I can't even put a word to it. It left me speechless as to the kind of support system we're supposed to be having for our children and youth in Ontario, and what we're having instead is conditions that are leaving them—we wonder sometimes why they're left the way they are, and this is the reason.

Mr Tang: Similarly, again when I was speaking to children and youth with disabilities, I remember seeing one youth who was Afghanistani in descent. She comes from a war-torn country and what happened was that she stepped on a land-mine. When we started a dialogue, she didn't want to participate at all; she didn't see the need for her to participate. She just didn't see anything out there for her. She didn't see a future for herself. She didn't see why we came in and how she could contribute. You could really sense the low self-esteem she had, and it's very depressing.

Mr Jackson: You've both identified issues around low self-esteem and both have identified it first in a gender context, and then you talked about racism. I guess discrimination against women or girls, or role modelling for girls or young women, is a form of racism. Would you not agree with that? Were you seeing elements of this in our school system?

Ms Wadhvani: Against women specifically?

Mr Jackson: Women role models for young girls, teens.

Ms Wadhvani: There wasn't a great emphasis on the whole gender bit, but what we did hear was that there is a lack of women role models for young girls. I don't know if you're familiar with the Aspirations Project Qualitative Research Report, but there were children and youth who equated success with a white male physician; that was success for them. For a lot of children and youth, colour is an issue, gender is an issue, and occupation is an issue. Yes, there is a lack of positive models out there for not only the young girls but children in general.

Mr Jackson: The other area that intrigued me that you raised was participating in decision-making. A legislative committee about five and a half years ago dealt with the issue of what's called alternative dispute resolution, ADR. Just to demystify, basically its application in our schools is teaching young people how to problem-solve and how to mediate so that it's a learned response. Then, when there are complications in later life between you and an employer, a spouse, your children, your friend, you're equipped with the tools.

Putting it in that context, were you exposed to any of these kinds of programs or did you see any evidence of them? Or, to reverse the question, is that the kind of thing you're leaning towards in terms of the fact that an empowerment model is an access to power? It's empowering the individual so they go into any situation empowered.

Do you want to respond to some of that: whether you were exposed to any of it, whether you're familiar with it, and whether this is the kind of thing we're talking about? It's something we can pursue.

Ms Wadhvani: We were exposed to some positive initiatives out there by youth, but what you're talking about is definitely what the youth are looking for. For them it's important to be able to apply what they're learning. When they go into a calculus class and learn a formula and don't know what that's going to do for them later in life and it's not realistic, they don't understand that now, and that's difficult for them to grasp. "What is this formula going to do for me when I'm 35 years old and I've got such-and-such a job? This makes no sense."

We need to do what you're talking about, to say: "Look, if you were in such-and-such a situation, you'd be able to solve it by using that calculus formula. That's how it's going to help you." If they realize that we can apply this knowledge in this way and understand that "Yes, this will be useful to me," it's good. It's knowing how to apply it.

But a lot of their courses and material just don't make sense. "I don't understand this. What has the history of Canada got to do with me now and in the future?" They don't understand. That gives them a barrier, and they say: "To hell with it. I don't want to deal with this any more." But when they're shown how to do it, and I think that's similar to the concept you're trying to relate to me, it is helpful, it is what they need. They need to know that this is going to be helpful for them, that I can apply this in my real life, that this works for me.

Mr Tang: I personally did not hear of any such programs from the youth I've spoken to. The onus was that they just felt excluded in terms of making decisions. For example, when she talked about curriculum, young people are never consulted about it. When we talk about proposed legislation, for example the anti-racism education bill, Bill 21, I believe, and Bill 79, which is the proposed employment equity legislation, not only are young people not included but they're never consulted on it. They don't feel they belong to the systems and that they really do have a legitimate say.

Mr Jackson: You made reference to the conflict between work and school, with work winning out too frequently. About four years ago, an educational committee I served on heard deputations from a group, and they defined this conflict between work and school; not simply the absolute necessity to find work but that within their cultural group, they were called upon to provide labour well into the night. It's all a matter of Hansard, but the Portuguese community do a lot of office building cleaning, and we had a strong presentation from a group of Portuguese children who said: "We really don't get home from cleaning our office buildings till midnight or 1 in

the morning. We're pretty bagged when school starts."

Are those the kinds of things you heard, or could you be a little more specific to guide us? Certainly that's an issue we'd like to look at a little more carefully. Is it more to do with the issue of, knowing how few jobs there are out there, that you'll do whatever it is to keep the job you've got? Could you help us understand that a little better? I wanted you to fill that out a little more.

1700

Ms Wadhvani: A part of it is that for economic reasons, children and youth have to work to help their parents. They find that they're not only going to school a full day, but many of them have part-time jobs, some for economic reasons, some because they need experience. It is an issue for them because studying time is lost, their youthful time is lost, their recreation time is lost.

One of the things we heard, though, was that for a high school kid who's not making it within the system, to drop out and get a job, whether or not that's available to them, is immediate gratification, because it's money, it's right here, it's right now: "I can buy what I want, I can buy the clothes I want, the car I want etc, etc, etc. The education system, which is not working for me, is bogus. It's something that's long-term and out there, and I don't know what it's going to do for me later, because now I'm seeing that people are coming out with their master's degrees, and they're not getting good jobs. If that's the case, why should I try at my education system? I'll go for the immediate gratification. I'll go for my job right now, because that's good for me at this moment."

Mr Hope: I'd like to focus on two parts. First is the 12 and under. You called them the babe category?

Ms Wadhvani: No, I said "from the mouths of babes."

Mr Hope: Okay. I want to focus on that category first. You talked about using art as a form of communication, a form of expression. With that artwork you saw, would it be different for somebody older to get a picture of what that person was explaining?

Ms Wadhvani: We didn't try it with the youth at all because we were able to discuss with them in conversation what they wanted to say. I don't believe that all youth are necessarily artistically inclined or geared that way, but for children it's part of their school curriculum. They're all involved in playing and illustrating and painting, and they do that all the time in school. That's why we used it with the children. I couldn't say for sure whether youth would feel exactly the same way or be able to portray—

Mr Tang: There could be similarities, or there could be opposites. It really depends.

Mr Hope: You used the word "art," whoever's artistic talent it may be, that they use art as a form of communication versus the verbal aspect because some younger children have a hard time understanding.

Nothing against Mr Beer, but would there be a difference in understanding between, let's say, a person of the young age of Mr Beer versus your young age of a drawing by an individual expressing something? Would there be a difference in your understanding of that

drawing versus the understanding of an older person, or would you be able to clearly identify what the artwork had expressed?

Ms Wadhvani: Even among professional psychologists, there's disagreement between the professionals. There may be a difference between the way I interpret it and the way Mr Beer interprets it, because I may be better able to relate to the youth, which is what we found with our consultation. The youth find it much easier to speak to a youth than they will to a non-youth.

Yes, there may be differences, but there are some very clear indications of illustrations that are set out. Kids usually draw about the most important people in their lives, as in the example I gave about the child who was drawing this big character and was saying, "Please don't fight me." That's an important character in their life. They'll draw about important relationships in their life. Those things are clear-cut, that I think we would be able to agree on. Specifics or the detailed psychological analysis of it is something we may be differing in opinion on.

Mr Hope: We were talking about a network, a communication system, leading up to a provincial conference. Before I move to that, I was interested in your comment about the seven-year-old saying she doesn't like herself. I have an 11-year-old, and every morning my wife goes through the fact that the clothes just don't fit right. It could have been a comment that was made at school about her appearance or whatever. I try to relate. I'm not that much older. I'm not that old.

Ms Sharon Murdock (Sudbury): Ha.

Mr Hope: I'm not. Don't let the grey hair fool you.

Ms Murdock: It's the job. It gives you grey hair.

Mr Hope: The job gets to you.

But that was there when I was young. Those types of things where people didn't feel they fit into a group were there before. Why has it changed? I'm dealing with a serious problem back home. There are frequently 14-year-olds committing suicide these days, and I guess I have a hard time understanding. This conversation takes place around arenas and everywhere else. What's so much different today versus the days we grew up in?

Mr Tang: I think a lot of things have changed. We live in a more complex world today. We're dealing with issues of AIDS. We're dealing with issues of racism, environment, and we're dealing with issues of employment. That was one of our most popular issues—that in this generation not only are we stigmatized that we're generation X, but we have no jobs out there. A lot of young people, that's the first thing they want. They want money. They want to be able to go to work. They want to be able to buy things for themselves; have ownership of their materials.

Ms Wadhvani: Yes, there are a lot of similarities between the problems of a generation or two generations ago and today. But what we also have to acknowledge is that, as Canada, we are more diverse than we were five, 10 years ago racially and there is a lot more promotion on our differences, our sexual orientations and our disabilities, and not that these things should be tolerated, but that these things have to be accepted. And to be

accepted is so important in the peer culture, that you're a part of a group, that you have peers who accept you for who you are, because there's a lot of peer pressure out there. It's not only the way you think; it's the way you dress, it's the music you listen to.

I thought I was in touch with some of the youth things that are going on and I found out new terminologies and new slangs. Does anybody here know what a wigger is? I learned within these consultations what a wigger is. A wigger is a white person who is trying to act like a black person. There's a whole different type of terminology within our youth today and we don't attempt to understand it. And it's so important that if you're acting that way, then you don't really belong, so you're outcasting you. It's a way to say that you're neither one nor the other. For some cultures, if you're not enough in tune with what the culture is all about and you're more anglo-oriented—they called it reverse racism, but that's not the correct terminology—then they outcast you once again. You're not Chinese enough, you're not East Indian enough—all the various different cultures. You're not Spanish enough. "You're not relating to our culture enough, so you're not listening to the right type of music."

There's a lot more than just belonging to a group. It's all the other various areas that I've just touched upon.

Mr Hope: I want to share some of my time with Ms Murdock, who has a couple of questions, but I'm wondering about this provincial conference. There has to be a way of getting the information to young people to speak to young people. What about our student council bodies of high schools? What about that? That way we can work on Kent county from a rural perspective, we're working on a county perspective or a city perspective into a larger one, and it just allows, as I take it to be, ownership, because my conversations with a lot of young people is to actually feel like it's ownership of a program or ownership of conversation that takes place.

We started a thing called the mentor program. You talk about young people looking up. I don't think my son ever goes out of the house without Gilmour's hockey sweater on. That is a mentor to him. It's a person he can relate to, that he has aspirations and goals.

1710

Around the student council, usually student council elected officials—people, youths—are mentors in a school program. What about using them as a key mechanism to lead to this provincial conference?

Ms Wadhvani: Two comments: One, I was in high school and I was on the student council and all the rest, and I thought it was a really good thing. It wasn't until recently that I realized that student councils are merely popularity contests, and that's literally all they are; they do not represent any diversity of the students in the high schools at all.

Second, just to make a point on the ownership idea, yes, it's important, but students—forget students; children and youth in general are never given ownership at all. They are never given the empowerment to make those decisions, to be given, "This is completely ours that we

have a say in it." It's very much influenced by the adult world.

Mr Tang: Also, just like the whole project itself, the whole idea of inclusivity. It's very important that we tap into groups that don't always have an opportunity to speak, racial minorities and aboriginals within rural areas, people with disabilities, HIV-positive students. These are students, or not even the students, who never have a chance to say what they feel.

Ms Wadhvani: And they're not represented either.

Ms Murdock: Mine's very quick. I just wanted to know if you're an example of the youth; in terms of being articulate, I must say you are exceptional. You sounded surprised when you talked about the sexual activity at the age level. When I was teaching in 1970, my grade 7s were sexually active, so I don't think much has changed in that respect.

My question is related to the compilation of the materials that you got and whether you saw any differentiation or did you differentiate between the regions or among the regions? For instance, is there a particular trend that you found in northern Ontario, which is where I'm from, as compared to southwestern, greater Toronto, Metro Toronto or southeastern, for instance?

Ms Wadhvani: Most of the issues we heard were quite similar across the board, especially with the education system; that was something that hit everybody. But there were some areas, such as when I went out to Ottawa, they spoke more specifically about teenage pregnancies, which isn't to say that it didn't exist in other areas or it wasn't prevalent in other areas; it just seemed to be a very big focus for them.

In the northern communities, suicide and sexual abuse were apparently big issues that we heard from some of the youth, but mostly we heard from non-youth who were helping us to have these consultations and these discussion groups. But the youths themselves didn't speak too much about them because, as we found out later, they're suppressed. They're not allowed to talk about these things because they're not allowed to open their mouths and divulge these family things or these personal issues for them. So they're not allowed to talk about it and that's why many of them didn't.

Mr Tang: Similar to what she said, the issues were very similar, but in terms of different contexts, I would think. I would say, for example, when I mentioned before about the education system, when I was in Niagara Falls they talked about the fact that Metro students are so much more fortunate in terms of having up-to-date resources, materials. They said that they have books from the Middle Ages, that nothing is updated and that they have a very limited computer system, CD-ROMs and all the other resources that all the other youths should have.

Ms Murdock: But your report is not differentiated—or is it?

Ms Wadhvani: There is one overview page that says that some areas focus on this and some areas focus on that, but we didn't note points that Ottawa is specifically only interested in this, but we mention that there was a strong point of note from that area.

Mr Ron Eddy (Brant-Haldimand): Thank you for your presentations and bringing to us the very important information that you are doing about children at risk; it's certainly very important.

My question is very similar to the previous one, but I wondered about consultation with rural youth. I believe it was 21 consultations you had across the province, and of course, we have about twice that many cities, large urban areas, but there is a great deal of rural Ontario there which, as we know, is composed of youth from small towns and villages, farms, and rural residential not connected with farms. I wondered about consultation with them and if you had some in the groups and what your findings were, whether they were any different.

Ms Wadhvani: A rural group that we did was in a place called Arthur. We went out there and it was the largest turnout of consultation that I had, which gives you an indication that there isn't much for them to do out there. We had over 43 people attending, which was a quite large group. Their biggest complaint was that there aren't any facilities for them out there. There is absolutely zero, and when they were given the opportunity to have a place to go, the police came in and kicked them out. It was an abandoned warehouse or something that somebody had said, "Okay, yes, you can use it," but they weren't allowed to stay there and they were kicked out.

Ultimately, what they told us was that they ended up going to drink, bush parties, driving under age—all of this is under age, of course—and they become sexually active because there is nowhere for them to go, there is no one for them to speak to. There aren't even movies and shopping malls and places like that for them to hang out in, as if they're allowed to go there either. We feel that because they have no place to go, they end up becoming involved in activities that may turn out to be criminal.

Mr Tang: Also keep in mind there were a couple of areas that we did want to tap in but because of time and money we could only go to specific areas.

The Chair: I'm just conscious of the time and knowing that there is going to be a vote which is going to limit us towards the other end. I know, Mr Hope, you wanted one short question. Go ahead.

Mr Hope: Just dealing with the economics, because you keep hearing the word "jobs" in the comments that were made to you and young people are looking for jobs. Did they have, other than using just the word "jobs," a system that they could be involved in to help create jobs in their own communities? Did they have ideas of, how can we be active in participating in employment opportunities in our community?

Mr Tang: Speaking to some of the youth, they're unaware of the programs that are out there. For example, even though there are programs, like the Venture programs or Jobs Ontario Community Action programs, you must have matched funding, and not all youth have that kind of money and that capital to put up. They see that there are temporary job placements that are put out by Jobs Ontario like Futures, but they're all very short-term, that they're only in the summertime, and the money that they get from it is not very much. But they are interested

in getting together, thinking of some kind of initiative that is self-sustainable but they just need mechanisms that will assist them.

Mrs O'Neill: If I may go back to Mr Eddy's question, did the youth in Arthur have any specifics that they felt would quickly or even in the long term help their situation, or are they just discouraged and turned off?

Ms Wadhvani: They are discouraged but they would really, really like a recreation centre. What they need is a boys and girls club of some sort. It is important that this recreation centre be run by youth, that it's not an adult supervisor in there who has set up all the programs but one that they're consulted on what's available within that recreation centre, that they have a say because they've got their own interests and needs, and that those are provided and that the supervisors and the mentors there are all youth. This is what they really, really want and what they really, really need.

The Chair: Just as a final question, in the four areas that you've set out, the fourth one was that youth want to have a place on decision-making bodies. What specifically were you thinking of there, that there would be, for example, a youth elected to municipal council or to a school board, or how specific did you get in that regard?

Ms Wadhvani: One of the things that we heard from the youth themselves was a youth Prime Minister. Why don't we have a youth Prime Minister? Why don't we have a Ministry of Youth?

Ms Tang: Or a youth secretariat.

1720

Ms Wadhvani: Or a youth secretariat. We feel that wherever there's a decision that's going to be made that affects a child or youth, there needs to be a child or youth on that committee. They should be elected into school boards, they should be elected into the ministries in the government, at the education level most importantly, because that's the second-most influential sector of their lives, and within the community as well.

The Chair: There's much in your report and we have all received a copy of it as well, which we are going to look at in terms of the report that we ourselves prepare. I know that if we had the rest of the afternoon, we could quite profitably go through other aspects of your report, but I want to thank both of you very much for coming before the committee, for providing us, as I said, with copies of the report. I think we recognize that in the short period of time we have to conduct hearings into the question of children at risk we can't possibly cover all of the various aspects, but the report which you prepared, along with other people in the province, is one that has certainly made a valuable contribution to our understanding of what those issues are.

On behalf of the committee, I want to thank you again for being here last week when we were meeting with the Premier's Council and also for coming back today and making the presentation that you have.

LOUISE SAS

The Chair: I call on Dr Louise Sas, if she would be good enough to come forward. While she does that, I'd mention to members that I got carried away by the colour

of this children's services report. It is actually in the material you were provided with. It just isn't as shiny as the one I was handed. We do have a copy of it.

Dr Sas, welcome to the committee. We have received a copy of your documentation, and we have half an hour. At some point a bell is going to go and we'll have to go away and have a vote. Hopefully, that won't happen until we've completed your testimony and questions, but we'll make sure we have the full time with you.

Dr Louise Sas: That's fine. First of all, I want to thank the committee for inviting me. I hope that some of the information I will provide you with today will be of some assistance.

My name is Louise Sas. I'm a clinical psychologist at the London Family Court Clinic and director of the Child Witness Project there, which is funded by the Ministry of the Attorney General. I'm also a mother of four young children, aged two to 12, which sometimes I think is probably the most important aspect of what I do with my life.

What you have before you are some materials that I provided. Because of the late date in terms of when I received the invitation, I wasn't able to provide you with a written brief, but we will do that and that will come within the next week or so. It will cover most of what I'm talking about and perhaps even flesh out some of the areas I don't have enough time to go into great detail on.

As I mentioned, I'm a clinical psychologist. I've been with the clinic approximately 15 years and as a result I've been involved in many different areas of clinical service. Before you is a very simplistic little diagram. It serves to illustrate the different areas of service that the London Family Court Clinic is involved in as a child mental health centre.

I'm going to go through each of these different areas because I feel it's very important for all of us to recognize that at the centre, the topic that we have here today, children at risk, we find those very same children in all the services that we provide at the family court clinic and many times the same children coming to us at different points of time in their lives. So that will be the common thread that I will be sharing with you, that if we don't take care of the children and provide for them early on, we're going to be seeing them later on in different capacities.

That's essentially what's happening in the first area I'm going to talk about, which is young offender assessments. We see approximately 200 young offenders each year who come to us via the court system for assessments. There are a number of us who do these cases, including myself. In many of the cases, they are involved in person crimes, sometimes very violent crimes that I think reflect the level of violence in the general society that we're seeing today. Many of the crimes that are person offences are also sexual offences that are perpetrated either against other children in some cases, or even adults in other cases.

Certainly, some of the crimes are very violent and cause an emotional reaction on the part of the assessors and the judiciary, the crowns, the defence lawyers and

certainly in the community at large. But what we're seeing is that behind each of these young offenders and behind the charges and pleas that they present with in the court are life histories, and they're disturbing life histories that I want to share with you because they really talk about that centre box here and they are very much at risk. More than any other area, young offenders, for me, represent a mixture of victim and perpetrator at the same time, given that they are still children but may very well be perpetrating crimes against other children.

At the clinic we're very concerned with the level of retribution and vindictiveness that we see in our society, certainly in the media, but I think the media are reflecting community's and society's concern about the level of crime that's being perpetrated by young offenders. Although I think we can recognize and appreciate the emotional outcry—and in some cases, it's probably very understandable—and the fact that people seem to want stiffer punishments and have a very punishing philosophy with respect to young offenders, our view is that there's a vast amount of research out there and certainly in our own clinical practice to show that that's not going to work, that punishing is not going to be a solution to make our society safer unless we start to address the needs of these children who are very much at risk.

Rather than focusing on identifying high-risk children for youth crime, what has been happening, I think, is that people have been trying to blame children, using euphemistic terms such as "accountability" and "responsibility" when what they're really just saying is, "It's all your fault." I think we've had enough experience at the clinic to see that that's not the case.

The incidence of child sexual abuse, physical abuse and witnessing family violence within one's home in the history of the young offenders whom we are seeing in our clinic is shocking; it is absolutely shocking. It's consistent with other studies that not only have been done in Canada but also in other countries, in North America and, for that matter, in Europe and Australia as well.

Just recently, the Metropolitan Toronto Special Committee on Child Abuse produced a report. It's a number of years old now, but I think what it described is even more so the case now, as survivors of child abuse are seven times more likely to be dependent on drugs as they become older; to be runaways—70% of runaways have been noted to have backgrounds of physical and sexual abuse. In fact, the children probably most at risk are the child prostitutes on the street where, when they were surveyed—numbers of them were surveyed—98% had been sexually abused within their home environment.

I think the reason we're finding all this out is that we're asking the right questions now and we didn't know how to ask them before. When I first started at the clinic, there was no question about sexual abuse. We didn't ask it, and we certainly didn't find it. Probably the first case I had was five years into my practice, where a young girl was depressed and after a lot of work with her I found out she was depressed because of an apparent suicide by her father. What I didn't know is that the suicide followed a disclosure of incest and I only found that many years later. It was a dead-end disclosure that went to

someone in the community and it was never brought out. We only found that information much later.

Having found out that information, we started to ask questions about a lot of the girls who came to our clinic as young offenders, who were not seen to be at risk in any way but who were committing crimes against the community; and more and more, in particular for the female young offenders, the number of children who had been sexually abused and physically abused within their home situation was absolutely devastating.

For many of the children we see in the young offender area, their homes have not been safe havens but rather highly stressful and abusive environments, causing sometimes physical and emotional harm but certainly scars they will carry for ever. That is why we feel very strongly that children are not solely accountable for their actions and are not to blame for everything that happens. At times, we fail to recognize that it's society's failure to provide the essentials of adequate care for them.

I met with my colleagues this week, and we all work in a number of different areas. We have a generalist model, and there are five psychologists at the family court clinic. I went to Alan Leschied, who has the most experience in the young offender area, and asked him for one recommendation I could bring to you in terms of the young offender area and children at risk. What he said was that we need to have the promotion of professional education on effective identification and prevention programs for children who are at risk for anti-social behaviour, that it's not enough to just lock them up. That's what he wanted me to bring to you today.

1730

The child welfare area is more my area of interest, certainly child sexual abuse, which I will do the majority of my presentation on. In the child welfare area, the clinic is seeing much younger children. We do a lot of consultation with local children's aid societies who come to us when they have cases going to court where there is a major legal battle ensuing over protection issues related to young children or a little older children within the home. The cases most typically involve child sexual abuse, physical abuse, neglect, witnessing violence, but they often have an unusual twist and they're very difficult cases to prove that anything is happening.

In anticipation of coming here, I met with a child abuse consultant at the children's aid society with whom I work very well, and I asked her what she thought the biggest problem was, why it was that even together we often could not provide a safe place for children. Of course she talked about resources, and we all recognize that with financial restraints there are fewer resources to meet the needs of children. But beyond that, she was talking about legislation, and I agree very strongly. The Child and Family Services Act, which I outlined just underneath the child welfare assessments, does not always provide us with the tools we need to intervene. They have some very narrow definitions in the Child and Family Services Act, especially in the areas of children at substantial risk, that don't permit courts of law to intervene in cases where at times intervention really must occur.

For example, if children have a steady diet of witnessing family violence within their homes, we know from our own research and research we've been reading that it's devastating for kids, that it has a deleterious effect on boys in terms of how abusive they will be when they grow up and on girls in terms of whether they will be victimized in their future relationships. But that is not necessarily part of the definition of "substantial risk" for a child. Many children who are in very violent homes, as long as they are not being physically hurt or sexually abused themselves—they could witness their mother being raped, they could witness their mother being assaulted, but the agency might not have the strength it needs to go in and take those children out, or to do the proper intervention.

Related to this is the whole area of custody and access, where again there are problems with the Children's Law Reform Act as well in terms of the best interests of children and protecting children in those kinds of situations. There are times when children have access to parents who are abusive within a family situation, where they have witnessed family violence, where the access is carried out under a very dominating and controlled setting where the children are fearful, because the law, for whatever reason, seems to value the parent's right to access to the children above the child's best interests and rights. I'm not suggesting that in cases where there is family violence there should never be access, but certainly we have to put children's risks first.

Last is the area I want to spend most of my time on, because that's the area of expertise I could bring to this committee that we've really spent a lot of time on in the last 10 years. The London Family Court Clinic has a Child Witness Project. It's most recently been funded by the Ontario Ministry of the Attorney General; previously it was funded by Health and Welfare Canada as a study. We've seen well over 500 or 600 children in the last six years. These are children between the ages of two to 18 who've been either sexually abused or physically abused. The majority of them have been sexually abused.

The numbers are increasing all the time, and I think the reason for that is that we've been successful, for the most part, as a society in telling children that they can start to come out and tell us about what's happening in their lives. The media, general public education, are having an impact on some children—not all, but on some children—so that there are more disclosures. As well, there are many more professionals in the field who know, like us, to ask the questions, so we're getting the answers.

So our case loads are increasing at a rapid rate, and children's aid case loads are increasing. In our own jurisdiction, they've had a 30% increase in one year in the number of cases coming through of child sexual abuse, and it's very hard to deal with, very hard. What's particularly hard is the kind of cases coming out now of very young children, that is, toddlers, where allegations of sexual abuse are being made. Believe me, you need a lot of expertise in the area of child development, interviewing skills, child sexual abuse, family dynamics, to know how to do an abuse investigation of that nature.

What we're seeing at the Child Witness Project prob-

ably reflects what's happening in many communities across the country, except that at least we're seeing it because there's a Child Witness Project. I feel very strongly that there are many child victims in communities across Ontario who don't have access to services we have in the London area. We're very fortunate to have a Child Witness Project that's funded, so that at least children who are identified as having been potentially abused and have to face a protracted court system will have people there who will take them through that system and will ensure that whatever services are necessary are going to be put into place.

That's not true of many communities. In fact, I get phone calls from all over Ontario, particularly from the north but other areas as well, asking me to come and provide expert testimony, to do something for kids who are going to have to testify, to do some kind of preparation or do some consulting with crown attorneys, who unfortunately don't always have a lot of training in the area. We can't service the whole province. We certainly service the southwest region and do a fair bit of travelling.

The areas we have tried to identify as of major concern have been criminal justice system stressors. There are a number of different ways one can go when a child makes an allegation of sexual abuse. It doesn't have to result in a criminal prosecution all the time. In some cases it can't, if the child is much too young or if the child doesn't even know who the assailant is. But in cases where the criminal justice system is brought into the lives of these children at risk, I firmly believe it's retraumatizing.

We've come a long way in legislation. I put down the two bills that pertain to the area I'm involved in, Bill C-15 and C-126, and I'm very pleased. A lot of us who lobbied for those changes are satisfied that there is some movement.

The problem is more in implementation and also in education. These children will come to courts telling their stories, and there's an incredible backlash now—I'm sure all of you are aware of it—against hearing that children are abused. We allowed them to say it for a little while, and now the door is closing. Even though the kids are getting into the court system, they are being traumatized by the process and also they're not being believed all that much. The conviction rates are not good and the sentences are really light.

In many cases, children will tell me that they are absolutely offended and hurt by having gone through such a process, by having told everybody what happened, to find out that it took them longer to prepare to go to court than the sentence that was delivered to the abuser—if there is a sentence.

I brought a study we recently completed. I could not provide 25 copies, because it was too expensive, but I'll make it available to the research committee. It's a follow-up study of 77 children in our area who went through the court system, who testified in court. They told their stories very eloquently about what it's like to be at risk, to finally convince somebody to pay attention to you and to have charges laid on your behalf, to be retraumatized in court, then not believed and have nothing happen and

have to go back to sometimes a very abusive situation.

The material in here is really very interesting in that it shows us we have to do more. If we're going to keep saying that we want to put children first and that we're concerned about children who are suffering from physical and sexual abuse or children who are witnessing violence, and if we're going to bring them into the court system in the mistaken belief that by having them testify and put away abusers everything is going to made all right, I think we have to be more accountable to the children themselves in terms of services and support.

The last comment I want to make is that one of the problems I have with bringing children into the forefront, bringing children into court systems to talk about their victimization, is that the way our adversarial system is set up, the children are not the focus. They are part of a process whereby they often become, I feel, pawns.

1740

When you speak to crown attorneys about the cases they have before them, generally the thought is that one prosecutes child sexual abuse or child physical abuse cases or violence or whatever because you're trying to maintain a standard rule of law in the country, that it is unacceptable to have that kind of behaviour in our country on the part of adults towards children. But the court isn't concerned that much about the individual child, and maybe it can't be. As a result, what happens to the individual child, the child's fears around testifying or everything that encompasses being part of a case, is not the major concern of the crown and generally isn't the concern of the judge either.

When we take children to court, we are there as advocates for them and support for them. To be perfectly honest, I see a lot of things and there are many times when I wish the children had not been brought in, even though the reason, supposedly, for their testifying is so they will be safe. If any of you have time to look at the report, you'll see that they only believe that till they've gone through. Many children will say afterwards: "I don't think it was really for me. I did it, hopefully, for other children" or whatever, "but I don't really think everybody's doing this for me." And they're right: I don't think they are. Maybe that's a focus we have to change.

I'll stop now and open up for questions, because I've tried to cover a lot of different areas in a very short space of time.

The Chair: You have, and I wish we had a lot more time, but we'll try to deal with as many areas as we can in the time available.

Ms Murdock: Thank you for coming such a long way for this. As you noted, northern Ontario is bereft of psychiatrists and psychologists to any degree and distance travelled is a real problem. It is such a major difficulty for us in the north to get doctors who are willing to come. Even though it's beautiful, it's very difficult to convince southern Ontarians that it is.

My question doesn't relate to that. It's more the concept of combining youth services, from Comsoc and the AG's office, basically forming a youth secretariat, and what your thoughts around that are.

Dr Sas: I would be very supportive of that. I would be very supportive of integrating all services for children, whatever legislation it would encompass; that there would be one umbrella agency or ministry that would take care of it all. We used to have it years ago. When I first started, that's what was in place. There were some difficulties at that point, but I thought at that time, but I didn't have a lot of experience, that rather than abandoning that format we could have done something with it to improve it. That's the way I would go now.

Ms Murdock: In terms of parole of young offenders who already are in the system, the parole workers certainly would like to see both of them joined, but you're saying the CAS should be involved in that as well?

Dr Sas: Yes. Mainstream integrated services for children so that body could then review all legislation pertaining to children. Right now it's divided into little pockets, but children cross these boundaries as they grow older and as they have different difficulties.

As I was trying to point out before with the young offenders, they're the very same children who a week or two ago were the victims of abuse. They also may be the perpetrators. We have some children who went through the Child Witness Project about a year ago who unfortunately are now the offenders of other children. We've actually been in the business long enough now that we're seeing that.

To me, the idea of an integrated service that carries children from birth up and meets all their needs would be a very good idea.

Mrs O'Neill: I wanted to go back to the Child Witness Project. There are two or three in the province, if I read this correctly. I wondered if there were recommendations that arose from the project. I have the same concerns you've expressed that there is a backlash. I think some of it is reinforced by some of the media. I don't know what that will do to families or even social situations, because I think it will reinforce the perpetrators and not be very helpful with the children. That's what the bottom line could be as a result of this. Of course, there are quite a few backlashes on several things right now, but this one particularly interests me. Did you have recommendations after this three-year study?

Dr Sas: Yes, we did.

Mrs O'Neill: Could you give us a couple of highlights of ways you feel this whole area of concern could be clarified?

Dr Sas: We had many recommendations. Maybe I should just summarize a few of the more major ones.

First of all, we felt very strongly that no child should be expected to testify in a proceeding without court preparation and support. That doesn't necessarily mean a CAS worker with limited court experience or a therapist with limited court experience trying to explain the system to a child, but some very specialized service so that there's a balancing.

Is that the vote?

The Chair: Go ahead and complete your point.

Dr Sas: Okay. That was one recommendation.

Another was that there should be mandatory education for judges—not offered if they feel like going to it, but mandatory—in the areas of child sexual abuse, family dynamics around family violence, and particularly things like delayed disclosure. Judges have a hard time believing why children don't tell, even though the literature's been out for 10 years.

Crown attorneys need more education as well, but they also need the time to put on these cases. What we're finding is that when the legislation first came out, crown attorneys were told it was a priority: "Red-flag these cases across the province. Make sure children are seen several times. Get to know the victim, get to know who you're taking to court." Now we're finding that they're so overwhelmed with cases, it's going back to where it was before. It was done for a while and it's not being done any more. That was another one.

Shall I finish?

The Chair: We've got 10 minutes. It's stacked votes in committee of the whole. We've got time, so please go ahead. I apologize.

Dr Sas: The word isn't out, but I feel strongly that there is a gender bias, that the criminal justice system doesn't deal effectively with all kinds of child victims in child sexual abuse cases. In particular, the system has a great deal of difficulty with intrafamilial abuse, abuse within the family. The family is still seen as a very private place where you don't intrude. The judiciary, I feel, still has trouble believing that stepfathers and fathers will abuse their own children. I'm sorry to say that it happens and it is happening, and there are times that the conviction rate in these cases is very, very low.

The other area of concern is adolescent girls. Girls are much more at risk in their families than they are on the street, and yet there's this great hype about stranger rape and stranger violence. What we've found is that the majority of the girls we see, and that's as young as two, are more likely to be abused by their parent or step-parent or an uncle or an older cousin in their own home than anywhere else. And boys are much more at risk for sexual abuse in the community, by coaches, priests, ministers, people involved in assisting them, particularly boys with single-parent mothers who really need that kind of contact.

The court doesn't respond well to all cases of child sexual abuse. The court also has problems in the area of very young children making allegations. Oftentimes these cases are difficult, but the judges don't understand the arguments that are being brought forward.

This backlash that you've described so well is a backlash that we knew would come. I'm surprised it took the few years we had. One social worker I talked to captured it very well. He said: "The first few years after Bill C-15 were the Star Wars years. Now it's the Empire Strikes Back." The empire is very, very strong and the children are disenfranchised, for the most part.

I'm not sure what we can do aside from education, and that's why we're trying to do much more expert testimony and trying to explain to the judges. I'm going to judges' conferences—I'm just one of many—trying to

say, "Of course it doesn't look like it happened; there are reasons for why that is," so we can get past that.

I think people would rather believe that children lust after adults than that adults lust after children. That's more comfortable.

Mr Jackson: Dr Sas, I appreciate your being able to come on short notice. I recommended that you come because I heard you present before another committee exactly a year ago next month. That committee has yet to finish its report. I'm hopeful this committee won't suffer the same problems and that your recommendations will make their way into a report.

I would just like you to respond to what the impact will be in those large communities in Ontario that do not have anything that resembles your program for the kind of dollar invested now through the Attorney General's office in two centres in Ontario. What kind of impact will that have? Is it not clear that there's a strong distinction between the services a child receives in a given community other than London by virtue of the program you offer?

Dr Sas: Yes. The results we have from our study suggest very strongly that the children who are prepared for testimony and who have the kind of support we provide give better testimony in a court of law. They actually do provide better testimony, as rated by crowns, and that was a blind study we did.

We also know that crown attorneys find the load very heavy. They find dealing with child sexual abuse very onerous. They are not emotionally prepared for it, nor are they trained, and they give up very easily. They can't keep doing it without the support. They do not have the time.

We feel we've made a difference in the London area, and I think you would find that it's supported by crowns and police officers, who feel they're not going through the motions for naught.

Mr Jackson: Is there less plea bargaining or the crowns simply saying: "This is a marginal call. We're not going to take it to court"? Is it that in your jurisdiction, there's less plea bargaining and that more come to court because of that preparation?

Dr Sas: No. It's actually very interesting. We've had a complete turnaround. We've doubled the number of guilty pleas. The defence lawyers are negotiating because they know they have strong child witnesses who are going to testify.

Our problem now is that even though we've done that and that's successful, with the ones that are going to court, the judges are still having a hard time proving beyond a reasonable doubt. They're stuck on that and they can't find them guilty.

The Chair: Dr Sas, I apologize for the way we have to end, but we can do a quick 30-second run to the Legislature. I want to thank you very much for coming and for the material. We're going to be in hearings for several more weeks, and if there's anything else, please forward it to the committee. Again, many thanks for your testimony today.

The committee stands adjourned until 3:30 tomorrow. The committee adjourned at 1753.

CONTENTS

Monday 16 May 1994

Children at risk	S-1491
Ontario Coalition for Children and Youth	S-1492
Zenía Wadhvani, project coordinator	
Chung Tang, assistant project coordinator	
Louise Sas	S-1498

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- ***Chair / Président:** Beer, Charles (York-Mackenzie L)
- ***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
 - Carter, Jenny (Peterborough ND)
 - Cunningham, Dianne (London North/-Nord PC)
- *Hope, Randy R. (Chatham-Kent ND)
- *Martin, Tony (Sault Ste Marie ND)
 - McGuinty, Dalton (Ottawa South/-Sud L)
- *O'Connor, Larry (Durham-York ND)
- *O'Neill, Yvonne (Ottawa-Rideau L)
 - Owens, Stephen (Scarborough Centre ND)
- *Rizzo, Tony (Oakwood ND)
 - Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present/ Membres remplaçants présents:

Jackson, Cameron (Burlington South/-Sud PC) for Mr Jim Wilson
Murdock, Sharon (Sudbury ND) for Ms Carter

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Boucher, Joanne, research officer, Legislative Research Service



S-52

S-52

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Tuesday 17 May 1994

Journal des débats (Hansard)

Mardi 17 mai 1994

Standing committee on social development

Children at risk

Comité permanent des affaires sociales

Enfants en situation de risque



Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Tuesday 17 May 1994

Mardi 17 mai 1994

The committee met at 1541 in room 151.

CHILDREN AT RISK

Consideration of a matter designated pursuant to standing order 125 relating to children "at risk."

BETTER BEGINNINGS, BETTER FUTURES

The Vice-Chair (Mr Ron Eddy): Good afternoon. Welcome to the standing committee on social development, which is now holding hearings on standing order 125, the designated matter being children "at risk."

Our first presenters are representatives of Better Beginnings, Better Futures. Welcome and please proceed, introducing yourselves as you begin to speak for Hansard. Please begin.

Ms Jassy Narayan: Good afternoon, Mr Chairman and committee members. My name is Jassy Narayan and I'm the project coordinator for the Onward Willow Better Beginnings, Better Futures project in Guelph. On behalf of the Ottawa, Kingston and Guelph projects that are here today and the other nine projects we are representing, we wish to thank the committee for this opportunity to speak to you about primary prevention and reducing risks for young children.

Better Beginnings, Better Futures is an exciting and exhilarating adventure which is all about children, increasing the protective and nurturing supports which they need within their families, in their neighbourhoods and in the wider community in order to grow and to thrive.

Our presentation today will demonstrate the working partnership among community members, integrating agencies and staff. Each member of our group will speak about a different aspect of the project. The six community members here today will tell you how positive changes are happening in their neighbourhoods and about the benefits of better beginnings to parents as well as children. An agency partner will talk about the benefits of integration of services, and colleagues will show slides and activities and also summarize.

I will frame our presentation using two overheads which guide our work. We think that primary prevention is based on some key values. I will briefly review four of those values with you on the overhead.

In Better Beginnings, Better Futures we have a holistic vision of children, where the child is not divided into parts to match the way we divide services. Rather services must be integrated to meet the needs of children. In Better Beginnings, schools, recreation agencies and communities are beginning to work together in the best interests of children.

Our second value is that we believe the policy framework for children's services must reflect the continuum of services, which begin with promotion and include primary prevention, intervention and treatment. Traditionally in Ontario primary prevention has been funded by demonstration grants which begin and end just when they're beginning to work. Primary prevention has to be recognized as an effective program component in the service continuum and resourced by ongoing funding and research.

We see the informal system as a key partner in the helping network. Better Beginnings, Better Futures has created healthy, informal networks in all the communities where they are located. Neighbourhood groups, parent peer support groups, teen drop-in programs, after-school recreation, play groups for little children and peer home visiting are some key ingredients of the informal network. The informal network is the primary buffer for families experiencing stress and distress.

Our fourth value is that the community must be recognized as a source of strength and wisdom for families rather than as a social problem. The community is never apathetic but always ready to become engaged in activities for change. You will hear this commitment and passion at first hand through the community members who are here today. Their testimonials and stories are multiplied 100 times in the communities in which they live.

In Guelph in the past six months community members have contributed in excess of 17,000 hours of volunteer work in their community's best interests. Community members have collected over \$30,000 in gifts in kind, such as food, bicycles, clothing, furniture and countless other goods, and they have distributed these without any intake process to families in their communities.

This community capacity we're talking about today exists throughout our province and our country and is the most underutilized resource that we have.

My second overhead you will see three times today or you will hear it referenced three times today. At the heart of Better Beginnings, Better Futures is the child, and we see these circles are nests that protect children. Our agency partner will reference these circles after.

The child is protected by the family. Families are supported to protect their children, the neighbourhood is resourced to protect families and agencies are engaged as the buffer with services that are sensitive and responsive.

I would like to turn my piece over now to Gary Zuber, community member.

Mr Gary Zuber: Good afternoon, ladies and gentlemen. Thank you for allowing me to speak here today. As Jassy said, my name is Gary Zuber, and I'm dreadfully sorry that I have to read off this piece of paper, but believe me, this thing is attached to my heart in about 45 different places.

In 1988, even earlier, when we moved into the neighbourhood in which we now live, I brought with me a family. I had very little hope, very little future and almost no self-esteem. When I found out about Better Beginnings, Better Futures and Onward Willow and became involved with them as an active volunteer, many things changed in my life, and I would like to reflect upon them now.

I had been witness to many dramatic changes in my neighbourhood, among my neighbours, my family and in my personal life. All of these changes have been for the better, and in many instances, they are still taking place, as we see these changes as a positive influence in everyone's life.

At a time when family values have taken a turn for the worse, I can see positive proof that our project is working and having a profound and far-reaching effect on many residents of what I consider our great community.

Through the hard work and dedication of the countless volunteers with Onward Willow, a great number of people have taken an active role in their own destiny. Just one of these activities is a safety committee, which was instrumental in having overhead lights installed at a dangerous school crossing. We worked hard on a project to have traffic lights put in at a very bad intersection. They're in now and our friends and family and children can cross with as much safety as can be expected at cross-lights.

We also succeeded in convincing Wellington and Guelph Housing Authority to install lights at both housing complexes, which house about 100 families, to install lighting at a cost of \$86,000, which was no mean feat, because of safety. They did this even though they had budget restrictions, and it has paid dividends through much more bonding of our community with the housing authority and with the safety for our families.

All of these actions show that we can have a say in the way in which we live and that we can get our message to those who need to listen the most, and I don't need to reiterate who that would be. Many volunteers stood on every team, every committee, every special group involved in our project. Their input is invaluable to the huge success of this project and many creative ideas have been implemented to make our neighbourhood a better place to live.

We have spoken before ad hoc committees on Bill C-69—a real piece of cake; a jewel if there ever was one—spoken at great halls of learning, hobnobbed with heads of state, spreading the philosophy of prevention as the answer to the dilemma of family breakdown. Our philosophy is reality. It works.

1550

We have spoken at all these aforementioned institutions about people trying to escape the web of despair

and hopelessness of the social service system. We have petitioned city hall many times and have been to many other functions too numerous to list. As Jassy said, and I broke it down even more, it has been conservatively estimated that volunteers spend as much as 1,200 hours a month at both centres. Figure that out at whatever you think would be a fair wage and it's staggering.

A lot of us like to put things back into the community. Because we can't work doesn't mean we can't participate. My hands do not tremble when I get my cheque at the end of the month. We have sat at home also planning fund-raisers or events, writing letters, phoning for information and distributing food throughout our community. We now reach a network of 120 to 150 families that share daily in leftover food from storage that otherwise would have gone in the garbage.

Many of my peers are actively involved in the workforce once again and many more are actively seeking employment now that their self-esteem has been raised to the level where they think they can participate. Very few of these jobs, however, are much above the minimum wage, mostly in the \$6 to \$8 range, but it gives us a sense of pride, of achievement, something that is sadly lacking these days. You know what the most amazing thing is? All of this stuff that I have mentioned is cost-effective. That's the key word: "cost-effective." It works; it continues to work; it will work for ever.

These actions are all cost-effective, as I said, and we are not all losers; we are not all users; we are not all abusers. Most of us care deeply about our future, our families, our province and our country and are trying to put something back into our system. Many more good things can happen; they will happen if we are allowed to continue.

We have just scratched the surface. We're learning how to walk and sometimes we stumble, but we are trying to take those first giant steps to self-esteem and dignity. We must persevere. We cannot let this opportunity knock and not be home. We are the way and we are the light at the end of the long, bureaucratic tunnel.

Frankly, we can be the salvation of a society falling into that despair. We have given ourselves a first taste of this self-esteem. We like it and we want more of it and we demand more of it. Please help us to carry the torch to future generations. As partners, nothing is impossible. As people reaching out to people, anything is possible. As partners, our project has embraced many diverse cultures of many different backgrounds and we have learned how to integrate a community into one loving place where people go to meet and greet and share that nurturing care.

Here is my hand, which represents many other hands. Reach out and grasp it and show everyone that all is not lost, that we have not become a society of non-caring people. Show us you care. You'll never regret it. Utilize the greatest asset you have: us. Use us. Show us how to do the things we need to do. Give us the support we need. I know little about politics and a hell of a lot less about policies, but you can mark this on whatever you have handy in front of you: The next party in Ontario that wakes up and smells the roses, realizing that an

opportunity has been put right in its lap, will be the one that will lead us out of this wilderness and into a more prosperous future. It is time, boys and girls, to stand up and be counted. Thank you so much for giving me this opportunity to speak.

Ms Nancy Beauchamp: I guess it's my turn. My name is Nancy Beauchamp and I'm visiting from Ottawa. I live and work with the Better Beginnings, Better Futures program. I live in the Better Beginnings area, which is a subsidized housing area. I've lived there for 20 years and I've also raised my family of six children there.

I must say, when I first heard about the Better Beginnings, Better Futures program, I went to scout it out. I learned and I watched. Play group was up and running, so I checked it out; it looked good. I thought: "My kids would have liked this when they were little, but now they're all grown up. But that's okay, we'll keep this going." Also, I heard about the family visitors program. They would offer support and advocate on the family's behalf, inform, cut through red tape. I thought, "Okay, this could work." I was sold.

The community house is a safe haven, an oasis of safety and security, a real caring atmosphere that feels good. To gain the trust of the community, staff worked hard at this. Not just another agency out to tell people how to live their lives, they went out into the community, did door-to-door. They were out in the community being seen, they had an open-door policy and never gave up.

People in the Better Beginnings neighbourhood used the play group, which is an excellent program. There are lots of kids, moms and dads and care givers who attend every morning. Also, there was a need for a park. Staff and community people talked Ottawa housing into funding and buying equipment. Now we needed to build it; no money to do this. Community people came out and volunteered their time. It was a great atmosphere and it brought the community together.

The community gives input on what they see would be beneficial for their neighbourhood. The biggest change in the community is trust. The staff at Better Beginnings not only work there but are part of the community. Whether the staff live in the community or not, they have become part of the neighbourhood. Need to talk? You will find a good, caring, listening person at the Better Beginnings house, and children of course are always welcome.

We created a women's group. Women got together and decided they needed a safe place to share their feelings. Many of these women were living in violent situations. Women who became part of this program became proactive, wanted to change things. They found their voice, they took power, left abusive relationships. Also, with this program we've included child care, which is very important, and transportation, to make sure the women can get there and back.

We created Women for Change, a popular theatre group. They perform skits on community or domestic violence, and this is to sensitize the public. They have performed for the children's aid workers, council members, teachers, social workers, Kiwanis Club and many more.

The newsletter is another way the community people can share their feelings and express themselves. Communities know more about one another and the fear has diminished.

Power has stayed with the community. Better Beginnings, Better Futures has not taken over. That is an important concept. They offer support, but they do not try to tell the community. They try to gain the trust, empower. They give power back to the community, and I think that's one of the most important things.

Also, there's no long waiting list to get our services, which you see in many, many agencies. When you're in crisis you need the service right away, and whether you're in crisis or not, if you wait until you're in crisis, then it becomes worse.

I think Better Beginnings, Better Futures has proven itself and I would like to see this program, because it took a lot to convince me and I am not easily convinced. I hope it will continue for a long time. Thank you. I will turn you over to Andrea.

1600

Ms Andrea Robinson: Thanks, Nancy. Good afternoon. It's a pleasure to be able to speak here this afternoon.

In addition to being a home visitor for Onward Willow Better Beginnings, Better Futures, I am a volunteer and a participant. Better Beginnings, Better Futures has made a big difference to me and my family.

Upon the breakup of my marriage, I spent a lot of time sleeping. I was too depressed to function. With the help of staff, I was able to come to terms with my situation. Even though I was no longer living in my beautiful house and was unable to socialize in the same circles I was accustomed to, I still had my children, the most important part.

As a home visitor, I provide support to families in four areas: play for children, nutrition, health and recreation. With children, I promote activities that stimulate normal growth and development. To promote healthy eating, I bring nutritional snacks to families. In the area of health, I will assist in the decision of whether the aid of a doctor is needed, or in some cases I can provide information on things to try at home. For recreation, I can enable families to access baseball, volleyball and swimming.

A large part of my work is to encourage families to participate in programs which are held at our centre. However, for some there is a reluctance to participate. Society has told them that they are no-good, beer-drinking losers who do nothing but sit back and smoke away the money they receive from social assistance. They have been mistreated and degraded by bank clerks, welfare and UI workers, grocery clerks, landlords, agencies which assist with food supplements and health service providers. Given these experiences, they have little or no self-esteem and definitely no self-worth.

Through in-home support, I acknowledge the skills they already have and help them acquire new ones. Even though in the wider community, being on social assistance is seen as less than respectable, these families are now proud of what they have achieved. No longer are

they embarrassed by the actions of their children in public places. By developing trust through community involvement, consistent visits and peer support, these families are able to accept themselves.

I think home visiting is one of the many important pieces in our project. For people who know what their concerns are and how they could best benefit, our programs are wonderful. For others, we need to dig a little deeper and let them know that they are okay and we care.

Our outreach to new Canadians has resulted in many of these families becoming involved. This is the first time they've been integrated into community activities. This has been good for them as well as those of us born here in Canada. It has taught us all to be more inclusive.

Through this process, many parents have reaped multitudes of benefits, such as returning to school, including university; returning to the workforce, such as Clara and myself; becoming community leaders, such as Gary; becoming more community-focused. Parents who have received this assistance are now role models for parents who need similar support. To view others going through this process has an empowering effect.

We are pleased today to share this with you. Prevention works, and we would like to see it developed in all communities.

We will now pass the chair over to our—what's the word?—cohorts.

Ms Clara Akinsemoyin: My name is Clara Akinsemoyin. I'm a volunteer and a home visitor working on the project.

As shown on our overhead, the child is the centre of all our activities. Our major task is to protect them by working towards removing or reducing any element of risk they may be exposed to.

As you are aware, our mandate is to ensure that the child is allowed his full rights to be a child or is empowered to exercise his right to play or his right to be nurtured and his right to be protected within a safe environment. We try to protect these rights through our various in-home and planned centre-based programs, which range from emergency food and clothing supplies to planned activities for different age groups of children.

In Guelph, we have expanded our focus to cover not only children of ages one to four, but those aged zero to 16 years. At present, about 200 children participate in activities on a weekly basis. Seventy children under five are involved in our home-visiting programs.

Some of the activities offered are in-home parent relief for overstressed moms, child care for infants and toddlers in our drop-in, parent-take-a-break and infant-and-mom groups. There are also preschool activities for children of new Canadians attending ESL classes. In addition, we offer seasonal camps during the March break, summer and at Christmastime for the benefit of older children. There are also drama groups, and the teen and junior rap for the older children. These activities help to provide extramural opportunity for children sometimes overburdened early with too much responsibility at home.

There are numerous benefits that our programs give to

our children, and these are obvious to everyone on a daily basis. They help create a safe environment for our children, who are learning through exploration and experimentation during playtime. They provide our children a space of their own and give them a sense of belonging. They give them a chance to feel loved and maybe—what would you say?—a focus of attention. They encourage the development of language and social skills and they help our children gain competence that enhances their feeling of self-worth. They give an opportunity to model good behaviour as parents watch. They provide an opportunity for regular healthy snacks. They give our new Canadian children a feeling of belonging to the group, thereby being less timid and learning to speak English faster. They also encourage the understanding of and respect for differences in other children, while teaching them to appreciate the world around them.

Our prevention program is cost-effective because it embraces a cross-section of our community children and facilitates their smooth transition into day care centres and kindergarten.

Fifty per cent of enrolment in our Willowdale day care centre is from the neighbourhood. It is also cost-effective because it helps detect early developmental delays by referring to appropriate services, and it gives a more extensive group experience than our project can provide. It is cost-effective because it supports parents to make informed choices when finding quality day care. It is cost-effective because it helps parents recognize illness early in their children, by maybe calling the doctor when a child rubs his ear, which is a sign of an ear infection: You call a doctor rather than take your child to the hospital emergency department.

We believe that prevention works because we see its positive effects on a daily basis. We know our parents need the continued support and encouragement of government funding for preventive programs like ours. If we all agree that our children are our number one resource in this country, then it surely is much more cost-effective to assist the parents of those young children who may decide either to stay home and nurture those children or opt to go out to work.

1610

Ms Brenda Lee Lowes: My name is Brenda Lee Lowes. I am a member of the community and want to tell you more about Better Beginnings and my family.

I became involved with Better Beginnings when I first became pregnant. My doctor recommended prenatal classes to get myself ready for giving birth. The prenatal classes were very informal and I met a lot of new mothers there. Better Beginnings has benefited me by helping me to get involved with the community and with other mothers. I have participated in the parent visitor program and have benefited from this program with a local mother who has helped me with common problems and everyday questions.

My children have participated in the parent relief and child care programs. I know my three-year-old daughter has enjoyed the other children and playtime; my younger son gets a break from me and I also get an hour or two of relaxation. I am also participating in the read-write II

program because I asked for some help to get my grade 12 diploma. Now I work at the centre and use parent relief and the care givers watch my son three days a week.

Another program I enjoy is Nobody's Perfect. Because some of the community moms join in, we can all talk and learn new things and get great ideas about how to enjoy being a parent and not to feel bad for making little mistakes. I enjoy the baby-and-parent drop-in program the most because I'm able to ask questions of local moms and answer their questions as well.

I'm also a member of the community action group. We have two meetings a month to discuss concerns of the community, with efforts to improve the streets, garbage pickup and getting crossing guards. We also try to get more mothers involved with the activities of Better Beginnings.

Thank you for your time.

Ms Lisa MacLean: My name is Lisa MacLean, and although I do not have children within the mandated age, I'm very actively involved in Better Beginnings for Kingston Children. In my opinion, Better Beginnings has offered parents an understanding of parenthood and the importance of a healthy, stimulating environment to the growth and development of children.

Programs are conducted in a manner that is neither accusatory nor condescending and in the language that each individual can understand: no \$40-textbook words. It is amazing what can happen when you take away blame and replace it with empowerment. For the children, Better Beginnings has provided a safe and friendly environment where kids are able to learn to interact with other kids in a positive manner as opposed to the survivalist tactics many of these children are forced to learn on the playgrounds.

One of the benefits of the Kingston site is accessibility to the programs. The sites are strategically set within the boundaries, providing access through taxi and bus chits when necessary, as well as being within walking distance to the site in one's neighbourhood. I do not believe any person within our boundaries wishing to participate in the programs would not be able to participate on the basis of access.

All of the special events provided by the Kingston sites in the past have concentrated on the ability of people to participate through the hiring of chartered buses and such things. I believe this to be one of the reasons we have been so successful. One of the first concerns expressed by community members was the ability to get to these functions. The same applies to committee meetings. Getting there was a major concern, as was child care during meeting times.

I had the opportunity to be one of the community members involved in the hiring process. Having never done this before, it was quite a learning experience for me and afforded me new insight into my community and the people living both within and outside the boundaries of the project.

The greatest percentage of staff hired for the Kingston project came from within the designated boundaries of

the project. Great care and much consideration were given in the choosing of the staff, and my opinion as a community member was always valued and respected. Hiring people from within the community was important to us, because people who do not live within the area and experience the struggles of everyday life in the north end, although they may have a very good understanding of what we go through, could not possibly have the compassion or drive to work wholeheartedly at making things change. You cannot judge another until you've walked a mile in their shoes. Life in general is hard, but life in the north end, as a single parent on benefits living in subsidized housing, is a daily fight. I'm speaking from experience.

Better Beginnings is a worthwhile project. In a society where help generally comes in the form of intervention after the fact, when it is often too late to set things right, it's nice to see a project concentrating on prevention. I'm a firm believer that children develop their personalities by the age of three or four, and with positive parental influence, good nutritional values and a stimulating environment, kids don't have to grow up to be survivalists. Instead, they can learn that life may not always be easy, but it will never be more than what they make of it.

Mr Moe Brubacher: My name is Moe Brubacher. I'm the executive director of the Family and Children's Services of Guelph and Wellington County, the children's aid society in Guelph and Wellington. I've been involved with the Better Beginnings, Better Futures project since we first started to dream about it over four years ago, and I've continued to sit on the management board for the project and be quite closely involved with some of the people who are here today.

Certainly, in my capacity within the children's aid society, I have a great concern for children at risk, for child abuse and for child protection issues. I have to say that the things you're hearing today are some of the most exciting things I've experienced in my work in our community. The Better Beginnings, Better Futures experience is exciting because of our joint, integrated focus on children. It compares quite significantly with what we tend to have in communities: a focus on organizations, a focus on systems. What we're seeing within Better Beginnings, Better Futures is a real focus on children, where the diagram that's up on the screen here shows how the child is in the centre and we together, as agencies, as the project, as neighbours and parents, are working together for the best for children.

The project brings together parents, agencies, schools and health organizations in an integrated way. One of the most exciting things is that we make decisions by consensus, and to see agencies and organizations that are typically fraught with turf issues and boundary issues being able to come together to work in a neighbourhood like this is really quite dramatic.

Finally, the project has made a real difference for children and families, and the people who have spoken so far can attest to that much better than I can. But it has made a difference in terms of child protection, in terms of child health, in terms of child care quality, educational potential for young people and personal and family

development. Moreover, the project has begun to have some significant impact on changes in our local system.

The project has shown that integration is possible. Integration among a neighbourhood, parents, schools and agencies is possible, it's practical, and, as people have already said today, it's effective and cost-effective. One of the things that is perhaps unique within our community is a developing commitment to this continuum, and I think you have seen something like this earlier with what Jassy presented: a continuum of service that links together care and treatment/prevention programs across a spectrum. Through some of the leadership provided by Better Beginnings, Better Futures, we've been able to develop a community commitment to this kind of continuum, which is a really central part of our system as it's beginning to develop.

When it comes right down to it, children who need care and treatment, children who are in families where crisis intervention is needed and children where prevention programs can be effective are probably the same children. So it's really critical that we be able to serve those children in an integrated way rather than carving children into pieces, be it in education, health, child protection etc.

1620

I've listed a number of the organizations that have been involved with the Better Beginnings, Better Futures program in our community. This isn't a comprehensive list, because I couldn't get them all on the overhead here, but these are some of the organizations that have been involved in an integrated way with the project.

The Willowdale Municipal Daycare Centre, as was mentioned, has provided some child care spaces for children in the project. The Wellington and Guelph Housing Authority provides us with an office program facility within the housing project. They provide summer recreation programs. The police have been involved in developing a Neighbourhood Watch program.

The Guelph Community Health Centre provides onsite medical services. You'd have to be there to appreciate the context, where we have medical services provided in a building that used to be an auto body shop that's been renovated. So medical services are available onsite, rather than people having to pack up the family and truck downtown, which is several miles away.

The boards of education have been involved with us in the ESL classes, continuing education programs, and a stay-in-school program, and we're beginning to do some more effective problem-solving together with the boards of ed around particular children.

The Community Mental Health Clinic provides youth and parent programs, again onsite. The Community Mental Health Clinic is halfway across town and very difficult for people to access. Onsite programs have been a major benefit.

The Rotary Club has provided some play equipment, the city of Guelph, as Gary mentioned, has provided the crosswalk and the stoplight as well as some recreation programs, and finally, family and children's services is involved in providing administrative support to the

program. But together as well we're working on a community child protection program. From our perspective, that's one of the most exciting things: to see the community taking an active role in providing for protection for children. It's not only a job for family and children's services, but the community has taken an active part in that.

I'll put up a graph that shows some of the impact on family and children's services' work in the community. First, follow the larger bars, those being the number of case openings we have experienced in the neighbourhood over the last four years. You can see that the number of cases we've been involved with has actually increased somewhat. On the other hand, our case loads have declined. What this says to me is that we are now able to intervene earlier in families with problems and we need to stay involved for a shorter period of time, because there are more family supports and neighbourhood supports, a network of supports in the neighbourhood, which means that our involvement doesn't need to continue, aside from the community involvement being. I'm convinced, much more effective than our case work involvement could be.

Finally, I want to point out some of the impact that the project has had on our system. Outside of the neighbourhood, the project has also had a significant impact on how our system of services for children is evolving. First of all, the whole idea of a holistic vision is that we're able to look beyond each individual agency's mandate and our own little boxes that we have traditionally been in. Through our experience together in the Willow Road area, we are starting to really live out a holistic vision.

We've seen that partnerships work and partnerships are effective: partnerships among parents, agencies and schools as well as partnerships among ministries. I think that's really critical for you. This project represents a real success, a successful partnership among the ministries involved.

You've heard today about the wealth of informal resources in communities. I would stress again that as we face this time when our financial resources are really limited, we have virtually an unlimited set of resources in communities in the informal sector.

Finally, as you've heard, prevention is cost-effective, and prevention makes a difference if we can turn responsibility for children back to our communities as much as possible.

In conclusion, I would appeal to you to seriously consider establishing a long-term commitment to prevention in terms of funding, legislation and policy; to look to develop legislation and policy to support prevention, to support a holistic vision to link together prevention, child protection, education, health and other services for children; to look to more interministerial collaboration for children, such as what has made Better Beginnings, Better Futures possible, because today's children really are the framework of tomorrow.

I'll turn it over now to our remaining two presenters.

The Chair (Mr Charles Beer): When we get to the question period, we'll try to bring everybody back up to

the table, because I suspect there are a variety of people. I apologize; I can't always see everybody back there, but you're welcome to the committee. Would you both introduce yourselves and then please start on your part of the presentation.

Ms Suzanne Flanagan: My name is Suzanne Flanagan. I'm the project coordinator in Kingston.

Ms Leslie McDiarmid: My name is Leslie McDiarmid and I'm the project coordinator in Ottawa. I'm going to spend a couple of minutes trying to put a few more faces and programs to the project. The slides are from Better Beginnings in Ottawa. Some of the programs are similar in some of the other sites, but there are other programs that won't be represented in these slides.

The first slide is of the Better Beginnings community house. All of the projects are neighbourhood-based so that they exist within a neighbourhood and become part of a neighbourhood. Better Beginnings is really all about trying to create opportunities for children to develop to their optimal potential but also about strengthening neighbourhoods so that they're healthy places for families and kids. The community houses and office spaces tend to be central so that people can access them. It's a place where people can drop in and just be comfortable and relax. Here you'll have volunteers, you'll have staff and you'll have community residents.

Because access is such an issue, many of the services we offer have to go into the community and into people's homes. Often you have toy-lending services that people have to get to. We've changed that a little bit and we have a toy-lending service that goes out. If you have a preschooler and a baby, it's very difficult to get very far and get a very large toy, so parents and kids can pick a different toy each month and it's delivered to their door.

This next slide is just to remind me to mention the options that people are offered. This is a parenting group that gets together weekly, and we try to offer programs so that people have choices. You may choose to go to a parenting group in the morning; you may choose to go in the evening, where there's child care and a meal; you may prefer to have one-to-one support through a family visitor. So there are a lot of options for people to use.

This is an empty room. I'm showing it because there's very limited space in our neighbourhoods. We have very, very limited space, so we have to be pretty creative and innovative to come up with a way of using that space the best way we can.

This is a space that we create into a play space for parents and kids each day. I just want to take you quickly through what that process is, because I think the commitment to quality is really important and is one of the cornerstones of Better Beginnings.

We start with an empty space and open a cupboard. I know it looks like a mess in there, but that's strategically placed or the cupboard doors don't close. Then we begin the process of taking everything out. We hang sails on the ceilings—actually, those sails were donated by a fellow here in Toronto—and begin to pull everything out of the cupboard to create really quite a precious space for

kids to play. I can't go through the intricacies of this play space because it would require a few hours' lesson on child development here, but there are many, many opportunities for children from zero to five to learn, and of course children learn through play.

That's a sensory table where they learn about weight and measure; an infant area where everything is low for moms and babes; a science area, depending on the season. There's a fish tank underneath there and lots of places to be creative. That just gives you a sense of people coming together in a play space that's created daily.

1630

This is the community nurse. We have a community nurse who is provided to us from our local health centre. The community nurse is able to provide well-baby clinics, weigh babies, talk about nutrition and provide health information to adults and to parents.

This is our bus, which was donated to us, and this is a picture of the children painting their faces and putting their handprints on it so that they own it, so that we decrease the chances of vandalism on the bus. There's a big difference between transportation that exists and transportation that is arranged. Transportation that exists is a part of the neighbourhood and provides much better access than transportation that continually has to be arranged.

This is Zahra, one of our family visitors. The family visitors provide information and education to parents. It could be on pregnancy, nutrition, childbirth, child development, games you can play with your child. They also provide social support and link people to other services within Better Beginnings and within the larger community. This is a picture of Zahra, who has brought somebody to play group and is sort of amusing the babe while the mom is off meeting other parents in the play space.

This is another picture of family visiting. Mohammed is a family visitor. He works a lot with new Canadian families, a lot around settlement issues, immigration issues and housing issues. We are able to service families in the language they know: We have family visitors who are able to speak French, English, Somali, Arabic, Italian and Swahili. It's important for people, in terms of access, to have someone who knows their language and culture.

This is Pauline, who is working with Lilly around budgeting and menu planning. So it's quite a holistic look at supporting parents and families.

Within Better Beginnings, we work really hard to strengthen neighbourhoods. This is a picture of a community potluck, where people come together to learn about each others' cultures but also to create space and time for people to talk about neighbourhood issues and what they want to change in their neighbourhood to make it better for themselves and their kids.

This is a picture of teenagers, because you cannot exist, neighbourhood-based, without involving everybody. There's a fairly high crime rate, or at least there was, in our neighbourhood. It was important for these fellows not to rip us off, so they needed to become a part of the neighbourhood. So "neighbourhood-based" really means

having a broad enough focus that you involve everyone and everybody feels committed to making life better for little kids.

This is just showing a magic show. It's saying that those 10-, 11-, 12- and 13-year-olds are important, and involving them within the community life.

We work with a number of organizations in different ways. This is a program that the young people have called Kids in the Hood. The police department in Ottawa provides us with a police officer one night a week, and we look at issues around policing and learn about policing. The hope is that these are the role models for the preschoolers. We want to change what the preschoolers are seeing and reduce the crime and vandalism in the neighbourhood.

The next couple of slides again just look at strengthening neighbourhoods. Better Beginnings and community associations and community residents have worked together to create space within the community to play. That's a basketball court. We've tried to create programs that don't simply focus on people's ability to parent, but allow them to network in different ways and build other skills. We have sewing; we have cooking; we have crafts.

Nancy mentioned the parent theatre group, which gives parents living on low income a voice to talk about some of the issues and to talk to service providers about what their experience has been like using service and what they would like it to be like.

The last few pictures here are about building a park. Again, Better Beginnings is about working with neighbourhoods to make things better for families and little kids. Nancy talked about starting with nothing and people voluntarily putting the park together. The fellow who is driving that whatever you call that digger is the next-door neighbour to the community house. All these people volunteered. We didn't really know what we were doing, and what would have taken someone two weeks took us three months, but in the end it did come together. People donated things, and parents and kids got together to talk about what they wanted in the park. It created a time when people really had to depend on each other. No matter who they were, they had to depend on each other to pull this off. It was really an exciting thing for the neighbourhood to go through the process of building a park. What they ended up with was really an exceptional park, one of the nicest parks for its size in the city.

Then we were able to celebrate, and so we held a large community celebration so that people could come out and really appreciate what they had done with really very little money but an awful lot of effort.

I'm going to leave you now with the faces of some of the men and women and boys and girls of various ages and different cultures, with very many life experiences, but all of these parents and children and care givers were able to find a place to participate in Better Beginnings, not because they were somebody in need of a service but because they were someone who was part of a neighbourhood.

Ms Flanagan: In all our presentations today, one of the things we haven't said very much about is the

research part of Better Beginnings. In all Better Beginnings sites, research is currently being conducted. Each site has a site researcher, and approximately 33 people have been employed by the research arm of Better Beginnings. The research groups are looking at how communities come together to put projects like these in communities, how agencies integrate their services to make the projects work, as well as how programs are developed and implemented in these communities. This information being gathered by qualified researchers will be invaluable to future generations who wish to implement the Better Beginnings prevention model.

More exciting, however, is the longitudinal study presently beginning with the families of children born in 1994 and of four-year-olds that will follow the lives of these children for the next 25 years to see if the prevention model has made a difference in their lives. Research over the past couple of years has been conducted with families of four-year-olds in all the Better Beginnings sites before the Better Beginnings programs were started so that a comparison can be done. The research is being conducted in a different way and directed by qualified social scientists.

Each Better Beginnings site has a research advisory group made up of community residents and agency representatives. This is in keeping with the prevention model of involving community residents in the planning, decision-making and implementing of the project plans.

Ms McDiarmid: I would like to conclude our presentation verbally and then Suzanne will draw more of a visual image of the way of working with Better Beginnings.

I'd like to frame our conclusion in our experience and what that experience has shown us. Because each community is different and may be diverse within itself, I will limit our experience and our lessons learned to process and not address specific programs within specific sites or outcomes.

Our experience has shown that prevention programs can work in at-risk communities when services work in partnership with communities so that decisions, planning, program development, implementation and evaluation are a shared responsibility between service providers, service users and concerned community residents.

We have learned that to be neighbourhood-based means not spreading ourselves too thin geographically. Neighbourhood-based is a reality when staff who live both within and outside the neighbourhood know people by name, by conversation and by mutual experience.

We have learned the value of time and consistency in building trust. Trust is the cornerstone of risk, of involvement and of participation.

We have experienced a different way of working, one that is inclusive, flexible, participatory and responsive. Often this means broadening our vision, our objectives and our programs. It means recognizing the holistic life of a child and supporting not only the individual life of that child but the lives of his or her brothers, sisters, parents and neighbours, the collective life of a community.

We have learned the meaning of access as defined by a neighbourhood, where accessibility is possible by walking with a stroller and two preschoolers, where you know the staff—some of them are your neighbours—where someone speaks your language and knows your culture, where no one tells you what to do and where you feel safe, safe enough to ask for help when you need it, safe enough to offer it when you can give it.

1640

Our experience has shown us that we limit the meaning and potential of integration by focusing on formal systems and not on less formal things like community associations, groups of concerned people, individuals. Integration, participation, shared goals and commitment are important at all levels. We have learned that one aspect of integration is when the givers of work, the doers of work and the users of that work share their visions, time, experience, expertise and decisions.

Finally, we have been reminded over and over again of the uniqueness of each of the Better Beginnings, Better Futures communities, and the struggle, strength, knowledge and potential for change that exist within each one.

Suzanne is going to do a visual image of the way of working.

Ms Flanagan: I just wanted to tell you that all the Better Beginnings, Better Futures sites are very environmentally friendly.

I want to show you how we see the Better Beginnings prevention model put together and how it works. We compare it to a bicycle. The frame of the bicycle is the government, which has provided us with the prevention model; the wheels of the bicycle are the agencies that keep the project rolling in the communities; the handlebars of the bicycle are the community which is steering it; the seat of the bicycle is the staff, which keeps it balanced; the pedals of the bike are the steering committees or action groups in each of the communities that give the bike energy; and the mirror on the bike is the research that helps us to reflect on what we're doing.

On behalf of my colleagues and community of people, I'd like to thank you for giving us the opportunity to speak with you today.

The Chair: Thank you very much. I realize that to be involved in Better Beginnings you also have to be an artist, so that's another quality.

I'd ask everyone to come back to the table—is it 10 people who have presented?—because I think there'll be some questions. I'm not saying everyone will be able to answer every question, but we have a few minutes, given the amount of issues you've covered, to allow for questions. I regret that we won't have an inordinate amount of time, but we will have some, and I think we want to make some for questions.

I apologize that I wasn't here at the beginning of the presentation, but as somebody who four years ago was involved at the beginning of Better Beginnings, Better Futures, it really is exciting to see what some of the things actually are. I had the pleasure of being in Ottawa, I think before the program actually started, but you were planning. We were at a centre, I think, Yvonne, and there

was a lot of excitement, and now, two and a half years later, we see what has emerged. It's nice to see that something that began as an idea has worked its way through.

I'm assuming, Randy, that there's going to be some kind of document that will note the various projects that have gone, where we can share this kind of information.

Mr Randy R. Hope (Chatham-Kent): My understanding when we kicked this whole thing off—I remember up in the caucus room when we announced who was actually getting what projects and getting this going—was that we would be updating ourselves on a more frequent basis as the operation continues so we can develop possibly more programs.

The Chair: Just sitting here today and listening to what you are doing has been useful not only for us but, because this is all taped and your words are taken down for posterity, a useful vehicle for other people to get a sense of what different communities are doing. For a number of reasons, it's great that you could come.

Mrs Yvonne O'Neill (Ottawa-Rideau): I want to thank each of you. I really thought I knew quite a bit about Better Beginnings, Better Futures, and I've tried to keep in touch with the program, but you have almost overwhelmed me today with possibilities that I didn't realize. You have done very well to balance your presentation; to encapsulate this program in one hour is certainly a tribute to each of you and the roles you play.

In the Ottawa scene, which I know just a little better, I think there was only one thing that was missed. You did talk about informal networks, but even business communities get involved with your groups. I'm sure many of you know that you can bring out the best in so many people, including businesses, including neighbours of the various centres where the projects happen.

I only have one question. As I say, I'm almost overwhelmed by the presentation. I didn't realize that you involved teenagers. I had this as a preschool, school-aged support kind of focus. Could you tell us a little about how you do that in a community, or some of the things you're doing with the teenagers? I think we're dwelling a lot on kind of the negative sides of teens around here lately, and you seem to have some very positive interventions or focuses, and that would be helpful to us if you could tell us. If you want to talk about those young people who might be on social assistance or young moms, I don't care which direction you take the question.

Ms McDiarmid: I can start. Our focus group is children aged zero to four, so most of our time and energy is spent working with families that have a preschooler. However, we work in a neighbourhood where you can't start segmenting it. When we said to parents, "What is one of your big concerns in the neighbourhood?" they were saying it's the 10-to-14-year-olds who are bored, who are breaking windows and in the park with the little kids, being poor role models. It was important for us to say, what is that we could do for that age group?

We spent some time trying to work with funding sources and community associations to build basketball

courts, and we spent some time creating what's called Kids in the Hood, which was an interesting community development experience, because community members invited the police services board to lunch to tell them what their definition of community policing was. They had the mayor and the city councillor and the other three members of the board hear what community policing was as defined by a community as opposed to a police department. It was a real learning experience for everyone in terms of how to get this police officer in our neighbourhood one night a week, but that's worked really well and it's included the group that has been very difficult within the neighbourhood.

It's important to include everyone in the concept that we're trying to make this a good place for little kids. We have a number of computers in our community house because of a research project, and when I first went to the neighbourhood I asked my neighbours, "Tell me who the five worst kids in the neighbourhood are who might rip me off," and the same five names came up over and over again. I went to those kids—I won't mention their names on the tape—and said: "This is who I am; this is what we're trying to do. I need you to help me. I need you not to rip me off because I can't do this if I'm worried about you ripping me off," and I said to them, "And let your friends know." Touch wood, they've never ripped me off. It's important in some way to make everybody believe and feel good about what you're doing, and that requires a lot of walking around, a lot of talking, a lot of broadening your goals and objectives.

1650

Ms Narayan: I'm Jassy Narayan, the project coordinator for Guelph. The process in Guelph started similarly, where the older children and their parents were simply there, but the teenage involvement came through the community health centre wanting to engage teenagers, the group of children that parents had identified as the most stressful part of parenting. That organization came along and started a teen drop-in program.

My first day at work, the parents said to me, "What are we going to do for my children who are older than five?" I said, "What would you like us to do for those children?" It started as an after-school activity program with funds that came to the project through our partners, the city and housing, so we brought in additional partners to assist with the programs for children older than five.

Leslie is right that the community felt divided. The children older than five simply are in families and they come along with their parents, and you can't divide them. The teenagers have a profound sense of pride in the words "Onward Willow." Gary's daughter has been a public speaker for her project. We have not had the resources as consistent and predictable as the Better Beginnings resources, but we have not given up. We haven't given up on alternative sources.

Mr Zuber: I'm Gary Zuber, a volunteer neighbourhood person and the proud father of two teenagers who live in the complex. I have a 16-year-old son and a 17-year-old daughter who have taken enormous strides in the last three or four years, they say because of me, and that makes me extremely proud.

My daughter, for example, now has aspirations of going through as far as she can to work with child studies, something she can help her fellow person, as it were, in life. She has a boyfriend who, two years ago—and he told me I could say this whenever I wanted to—was headed for disaster. He was on probation. He went back to school and he's getting straight As, he's a role model in the community. And there are other teens in our community who are also role models who go by our place every day.

Unfortunately, when we were mandated four years ago with Better Beginnings, Better Futures, 85% of all the money we spend has to go between zero and four. You wouldn't believe what we've done with 15%, because we divided it 16 different ways to try and keep programs alive. There is a profound sense of loss in our community because we no longer can access enough funds to keep these teen programs going. We need to take a real serious look at how we're going to do that in the near future. I'll tell you, there are some powerfully strong, smart young adults out there who could help us to turn the problem around in our community. How else can their brothers and sisters learn, unless they learn first? This is why I say we really must look at this hard and long, involving teens.

The Chair: I regret very much that we're running into a time problem. I have both Mr Martin and Mr O'Connor, so I am going to go next to Mr Martin.

Mr Tony Martin (Sault Ste Marie): I am very envious of what you've accomplished, because before I came here I was involved in putting together a proposal for Better Beginnings, Better Futures, and we didn't win the lottery. We saw it very much as that.

It's an excellent program, obviously, and it worked out like so many of us had hoped it would, but our failure to not really be able to motivate the community to actually take it on by itself is what I'd like to focus on.

This program represents what could be done. It would be fairly expensive if we were to put it into every neighbourhood in Ontario at the cost we're incurring here. I'm wondering what success you had in involving the community that's already there in picking up the pieces and working with you and perhaps then sharing it with their neighbours so that it could begin to happen in significant ways that wouldn't be expensive.

In my experience, it seems to me that as we get into the question of community mental health, often the piece that's left out is the community itself. We bring in the experts and expect they will fix everything, when in fact they can't. It's just not possible.

The neighbourhood, the parents, the agencies—did you involve anybody else? The churches?

Ms Narayan: There's a large network of agencies now for which the ministry's collecting statistics on gifts in kind. Carol Russell can arrange for you to hear what the collective contribution is of agencies, churches, other ministries to the process. The contributions are astronomical.

I don't agree with you that Better Beginnings is expensive. One young person going through the young

offender system costs in excess of \$100,000 a year and in mental health it's about the same. We think prevention is cheap. There are over 200 children in this little community of Guelph. It doesn't even look at Ottawa and Kingston. In terms of contribution, the parents are already contributing in excess of what they had envisioned themselves doing. Andrea works half-time and contributes the other half-time in volunteer work.

I'm suggesting that we look at cost-benefit analysis within a different framework. The traditional framework is going to not get us very far in reassessing resources. There are other people here who could speak to the same issue. Churches are involved in what in Guelph we are calling the spinoff community. Two other neighbourhoods in Guelph came to the Better Beginnings neighbourhood and said, "How can we get started?" and two churches just assisted.

We are counting those resources. Those are going to be available for you through the ministry staff, in terms of what the collective contribution is.

Mr Larry O'Connor (Durham-York): I appreciate you coming here from all your communities. I agree that prevention and promotion is probably a huge savings to us and to the taxpayers who might be following this today.

There's one area that piqued my interest. I can see that probably a number of you have grown quite a bit with your involvement in the community, and I know that the more active people become in the community, the more they grow, and the community actually gains from it.

Was it Nancy who commented on the peer home visits? I was wondering if you could comment a little more on the peer home visiting and how that works, some of that process. Andrea might have mentioned it as well.

Ms Beauchamp: In our community they're known as family visitors. How it works is that Better Beginnings does not force this on people; it is a voluntary thing. If a family wants to access a family visitor, that is done. Then it proceeds that once a week, family visitors will go into their homes and will do whatever the family wishes.

We serve a lot of single parents, so many times it's support. The person needs to speak, needs somebody to listen to them. Isolation often is a very big thing, even though it seems strange to say "isolation" when you live in a community that's sort of on top of each other. But that is one of the big things, because there's not a lot of money, there's not a lot of resources, they can't get out of the community, and they often feel isolated and alone with nobody to help.

Also, they've been involved with many other agencies that have led their lives, told them what to do. They know what they need: They just need some support to find the resources, the information, as I said previously, cutting through the red tape, finding what programs are offered for their children; for themselves, some may want to go back to school, and how to access day care could be very confusing for somebody. It's just leading the way, not doing for them, but showing.

We deal with children four and under—that's our

program—so it's also modelling, going in and not saying: "This is what you're going to do to make your child listen to you. This is how you feed your child when it's first born. Yes, you must breast-feed." It's by modelling, it's suggesting, it's offering parenting courses if they wish to go. If not, then we will bring the information to them, we will bring videos. We will let them choose; we will not take over their lives. We will listen to what their needs are, what they want.

1700

To me, that's very important, because as a parent who has raised six children, I must admit I've had a number of different agencies in my life since they were born. Now my youngest is 18, but I remember at one time I think I had at least a dozen people from different agencies telling me what to do, how to live my life—"This is the best way"—which way to go, which way to turn. It got to a point where I was so confused and thinking I was such a terrible mother, I didn't know how to take care of my kids. I remember being involved with the children's aid, myself going there, accessing the service and their telling me they weren't a babysitting service when I was just asking for support. That's what family visitors offer. No, we're not a babysitting service, but we will certainly access the services and try to give them to the families who wish it.

I think that's the greatest thing about it, that it's volunteer, it's not essential, it's supportive and it's caring.

The Chair: Thank you. I'm really sorry that I have to be the heavy as the Chair, but I'm afraid we have several more presenters this afternoon. I do want to thank all of you very much again for coming before the committee. When we were originally trying to figure out how we could get more people into these hearings, we were hoping that, as all of you were involved in a Better Beginnings project, you might perhaps even know one another and, if not, it might also be good for you to get together in a collaborative approach. This has been extremely helpful to the committee. Again, thank you all for being here today.

Mr Zuber: Just before we go, I'd like to give you this button on behalf of Onward Willow. It represents what we're all about. Every time you look at it, I hope you think about us and see what you can do to help us out.

The Chair: Fine, thank you very much.

DILICO OJIBWAY CHILD AND FAMILY SERVICES

The Chair: Members of the committee, the cooperative spirit lives on in terms of our witnesses. I want to thank Ms Anne Telford who was going to be our next presenter, but we're going to switch the next two because Mr McKay, who is here from the Dilico Ojibway Child and Family Services, has to catch a plane back up to Thunder Bay.

Wally, we're delighted that you could be here today with us. If you would come forward, we'll just take a minute to get ourselves reorganized. Everyone just take a breath. I notice people were just having a last word with some of the individuals.

We move to our next presenter, Mr Wally McKay,

who is the consultant with the Dilico Ojibway Child and Family Services. It's been a long time, but it's good to see you. Welcome to the committee. We're delighted that you are able to join us from Thunder Bay. Please go ahead with your presentation.

Mr Wally McKay: Thank you very much, Mr Chairman. It's good to see you again. It's been quite some time.

Dilico Child and Family Services is an approved agency under the auspices of the Child and Family Services Act. At this time its responsibilities include the delivery of prevention programs. It has functions to provide counselling and to deliver a wide variety of family support services.

Dilico has been organizing and has been undergoing a process of preparation for undertaking a mandate as a children's aid. With this process Dilico has been examining options on mandates. Presently, Dilico Child and Family Services provides services to 12 first nations within the territorial catchment area of the Thunder Bay Children's Aid Society. Another first nation that is presently serviced by Algoma Children's Aid Society has made application to become part of Dilico. This first nation is within the recognized treaty region with the other Dilico first nations.

This presentation is in response to your invitation for Dilico Child and Family Services to address the committee's task on the fundamental issue of protecting children at risk. This presentation will address the matter from the first nations' concern on the legal requirements as outlined in the CFSA and its impacts on first nations.

Secondly, we will present briefly how the same act works contrary to the first nations we serve, under the title "Child T."

Lastly, we will present an option that our first nations are pursuing by which our peoples will be empowered not only to resolve the present matter before the committee, but which will also remedy the present inadequate and inappropriate child care regimes that are there.

Prior to presenting the specifics of issues on children at risk, the committee members must realize and understand that our views are presented from the realities of our first nations. These realities include peoples who, since European contact, have been subjected to an assault on their traditions and cultures. These peoples have endured the ravages of an era whereby assimilation policies were deemed the only answer in the federal and provincial government policies for first nations peoples.

In the majority of the communities, these peoples have 90% unemployment. This is not an occasional statistic but a year-round reality. These peoples in most cases live in conditions which could be justifiably termed as Third World conditions. The homes are in many cases inadequate, with no proper water and sewage infrastructures, which are taken for granted in many urban settings.

These peoples are constantly required to conform to legislative requirements which are in many instances very humiliating to them. I have seen middle-aged first nations peoples who have hunted and trapped as a vocation all their lives be subjected to study and write exams so they

can have a hunting permit. The humiliation is that they are treated in the same context as a non-Indian youth of 17 years who has not had any experience with outdoor life. This is an example whereby Ontario legislative measures in many cases are not appropriate and only create exasperation and frustration.

These peoples have lost a large population of their children, stemming from the efforts of another society to help. Instead, our children and families have been dislocated. We have lost many of our children due to the fact that the outside society did not understand; neither did it take into consideration that we are different and that we have our own standards. Instead, we lost our children, based upon another society's standard. Today we are in the midst of repatriating, reorienting and reintegrating our children who were taken away back into our families and into our communities.

The members may say to themselves that what is being presented is something that they have heard before and these statements are not pleasant to hear. The presentation of these facts gives us no enjoyment, but they have to be stated. Before the committee members decide to legislate changes, remember what we, as first nations, have gone through. Before any plan is instituted, it will be most wise to inquire and see if we have truly put our minds together.

The committee members will have been thoroughly briefed on the various sections of the Child and Family Services Act dealing with the protection measures and what constitutes children at risk. The first nations which are within the catchment region of Dilico Ojibway Child and Family Services have the same priority agenda in their plans. As we review the approaches utilized by other institutions, we, as first nations, must also contend with families that are at risk. If a child is at risk, then the family is at risk. Valiant efforts have been made to use an isolated approach whereby a child is removed from the present dangerous environment. Is removal of a child the answer? The members must understand that usual measures of child removal within your society are not necessarily the appropriate measure within a collective society of first nations.

Under the legislation, the removal of children from a family must undergo certain degrees of application based upon a service plan which is presented to the court. If there is no progress with the family, eventually the agency will ask the court to terminate parental responsibility. The executive director has the responsibility to seek such an order. The executive director is viewed as a person who is sanctioning such action and therefore is the individual who has the responsibility to direct that the parental responsibility be terminated. This measure is an affront to our tradition. In our culture, only the Creator has the right to terminate parental responsibility. In our effort to protect our children who are at risk, we assume responsibilities and mandates of your government, which in turn creates offensive actions on our culture and beliefs.

In the Child and Family Services Act, it recognizes that customary care is an option whereby agencies may utilize to provide services to first nations families. The

inclusion of this responsibility in the Child and Family Services Act was heralded as a major recognition of aboriginal family practices. Instead, customary care has now become a major preoccupation of service providers as to what it is and how much it is going to cost. Customary care has become a secondary service process. It is tried when all else has failed just to satisfy the requirements.

1710

Above all, we have seen customary care being the subject of legal argument between the lawyers representing agencies, children and families. We have witnessed non-aboriginal lawyers and judges make final decisions on customary care. What do they know about customary care other than what is explained to them? They have never experienced the true spirit of first nations customary care.

Given the economic status of our communities, then it would be fair to state that the majority of our first nations children are at risk. If we use every criteria established by mandated agencies for placing children, then most of our families are automatically disqualified. Then we will continue to lose our children. Our families will continue to be dislocated. The cost will continue to escalate.

Prevention is the key element within our first nations in order to reduce the risk level of our children. Prevention must be viewed from a holistic approach. Our children are very vulnerable to being abused physically, mentally and sexually. Of all families within the Canadian society, our children are more apt to be abused due to factors outlined at the outset of this presentation.

On May 28, 1993, Catherine Beamish, a solicitor from Sioux Lookout, handed in her decision as the director in the matter of a director's review pursuant to section 144 of the Child and Family Services Act. The director's review undertook the matter of the handling of the case and placement of child T. In this particular review, child T is an Ojibway child, a member of Long Lake No. 58 First Nation. Child T was under the care of non-native care givers.

The director was appointed on January 1, 1992. The review held 44 days of hearings from March 1992 to April 1993. There were five lawyers representing the five parties that were given standing. The conservative cost estimate is near \$500,000 for the review. Dilico Child and Family Services was given a standing to this hearing since they were involved with Thunder Bay child and family services with this particular child.

The director decided that in "the decision not to place child T with the T family"—which is an Ojibway family—"the Thunder Bay Children's Aid Society erred in its assessment of his best interests." She goes on to state, "Should it be necessary for me to find that CAS made a jurisdictional error, then I find that their failure to give sufficient weight to the legislative provisions with respect to preserving the child's culture was such an error. I therefore rescind the decision of the CAS refusing to place child T with the T family for the purposes of adoption."

Then she goes on to make a second decision after she

has weighed all factors: "That in the best interests of child T, he should remain in the C home"—which is not aboriginal—"and I place him there for the purpose of adoption. I recommend that any further period of adoption probation be dispensed with, and that the adoption be finalized as soon as possible."

The community and Dilico Child and Family Services lost another child. The cost to participate is high. The results of such decisions are devastating. Is child T at risk? We believe child T is at greater risk than he was before. The legal process is adversarial. It promotes winners and losers. This process is alien to our culture. Although it is clearly spelled out in the CFSA that aboriginal children are not to be adopted out to non-aboriginal families, there is a recognized legal process whereby the law can be circumvented to a purpose. Our confidence in the law and the purpose of law is fading.

It is our belief that Dilico Child and Family Services will not be dragged into another director's review pursuant to the Child and Family Services Act. This past review has demonstrated that although the law is explicit, the intent of law and how it is carried out is not always what is expected.

Presenting a change: need for first nations jurisdiction on families: Dilico Child and Family Services is presently examining options whereby it will assume the mandate for the total responsibility for children and families. The present options available through the CFSA do not meet the needs of the Dilico first nations. Discussions and preparations are being carried on at the community level to address the most favoured option. The first nations must have the right to have total jurisdiction over their children and families. Our first nations want and will exercise their right to reassert their standards and laws as they affect their children and families. The time is upon us whereby the Ontario government must realize that the first nations have the capacity and the knowledge to undertake the basic human right of looking after its own and preserving its children, its future, in a healthy atmosphere.

The present option whereby a first nation agency must embrace a legislative process for a mandate is unacceptable. The examination of the results from such endeavours reflect high costs, high intake services and, above all, that the legislation at times requires first nations to carry out decisions which are contrary to certain first nations fundamental principles.

During the International Year of the Family, it would be appropriate that the Ontario government begin a system whereby Ontario would engage in a process of vacating its jurisdictional field under child and family services and to enter discussions whereby Dilico Child and Family Services first nations would occupy the jurisdiction. In the end the first nations must have total responsibility for their children and families.

In conclusion, we have put forth the following recommendations for the committee's consideration:

(1) That the first nations have the opportunity to define the terms and conditions on what "child at risk" would constitute. This definition would set out certain standards that would be utilized in order to assume the child is at

risk at a first nations community.

(2) That prevention is the key element to reducing the level of risk to children within first nations territories. Additional cultural programming on prevention is essential in order that major inroads are made to stabilize families.

(3) That children are not viewed from an isolation view but that our family concept be reinforced in the planning and in services with first nations.

(4) That customary care practices and procedures be clearly established and enunciated by first nations within their territories. These practices and procedures will be guidelines that the legal and judiciary will reference if required.

(5) That if a director's review is required, the Minister of Community and Social Services be permitted to intervene together with the impacted first nation on the matter. Thereby such action could resolve a potential adversarial situation.

(6) That the Ontario government enter into discussions with Dilico Child and Family Services first nations on jurisdictional matters on families to coincide with the International Year of the Family.

Thank you very much.

The Chair: Thank you very much for the recommendations. Just before opening it to questions, can I just ask you, in addition to Dilico, Weechi-It-E-Win and Payakotayno both operate child and family service organizations, if I recall. Are there others now from the native community that operate their own child and family services?

Mr McKay: Yes, there is Payakotayno in James Bay and Weechi-It-E-Win in the Fort Frances area, and of course there is the Ojibway Tribal and Family Services in Kenora. The first one I was instrumental in is Tikinagan child and family services. We have a number of other agencies in Ontario that are being established in the North Shore, Sudbury, Sault Ste Marie areas.

The Chair: And those are formed through an agreement between yourself or that particular organization and Community and Social Services?

Mr McKay: Yes, each of those areas have entered into agreements with Community and Social Services for the establishment of those services.

1720

Ms Jenny Carter (Peterborough): I think you've expressed the problems very clearly and what you have to contend with and how you're losing children. I was just wondering if you could explain a little more what customary care practices and procedures are in effect; in other words, what the alternatives are, how the community would cope with this problem of children at risk.

Mr McKay: In terms of the customary care practices of first nations, you must look at the fact that we have a number of tribes or nations in Ontario: the Cree, the Ojibway, the Ojicree, the Mohawks and so forth. Each of these nations has a way of how they handle family problems. The Cree have their own systems. For instance, during the early times we never really had unwed mothers, but if it happened, it would be dealt with under

the traditions of the Cree people. The way the Cree people handled that was different from how the Ojibway handled it. Each of these nations had their own ways of how they handled these things.

And that is not only in that particular area, but in all areas of child rearing. Each of the children were given responsibilities at a very young age in terms of what they can look forward to in life. It's unfortunate that we look at customary care from the aspect that where there are problems, we must have customary care. There's also a positive side that we're not looking at, and that's going to be the reinforcing factor to have stabilized strong families within each of the nations. In the act, it appears that, "If there are problems, let's try customary care." I think if there are no problems, we should still use customary care.

Ms Carter: You're saying that if customary care were in being, in other words, if the community were functioning in a traditional way, a lot of the problems would never happen.

Mr McKay: In the act it's called upon to be used when you have problems. If it were looked upon from the positive aspect and financed, with resources made available to Indian communities—customary care is so needed now in a positive sense, especially after we have a generation that has gone to residential school systems.

I'm a product of that residential school system. I did not know how to relate to my wife or to my children, because I was taken when I was only six years of age and the system of residential schools was very militaristic; we were given orders and everything was done by bells. I never knew how to relate to my children. Instead of talking to them, I was giving orders.

That's where customary care would be really great at this particular time, to be able to capture that generation. Customary care is a positive way of dealing with teaching that generation how to be parents and how to be good fathers and mothers.

Ms Carter: But the tradition is still alive with the older generation?

Mr McKay: Yes, the customary care procedures and practices are very much alive. The problem we're having is that there are certain procedures and requirements under CFSA that we have to put in place to carry those things out, and then when we try to implement the positive parts of the customary care, they start to clash.

Mrs O'Neill: Mr McKay, thank you very much for coming, because you definitely bring a very different perspective. I want to use my time to speak to your actual presentation. I wonder if you can tell me a little more about both recommendations 2 and 5. What do you feel we as government legislators could either know or help give a way to in terms of prevention that would fit your concept? I'm very happy you brought the adoption issue forward, because it's one that I know has caused much grief. Could you say a little about what you think legislators could do to help your communities in the area of prevention?

Mr McKay: In the area of prevention, the time has never been more required that prevention has to be the

key element in addressing the issues. We have communities in a state of Third World conditions, but on top of that, individuals have gone through a process where they have been dislocated by other systems.

When we look at prevention, we look at it from the sense that we need programs where you have to key in on certain families or certain groups of families. We're finding that we have people who, because of drug and alcohol programs, because of their traditions returning, are leaving drinking and alcoholism behind. We're having the greatest recoveries of people from alcoholism, but what's happening is that they're going to another form of activities yet still neglecting children. We have to develop prevention programs that will look at parenting responsibilities, look at cultural responsibilities.

The other aspect we're having problems with is that in any program we do, there has to be separation between the church and government programming, that you can't include these two together. We're having a real problem with that, because in the first nations, you cannot separate those two. You have to include those two. We believe, because of our relationship with the land, we are very spiritual people in that regard.

That is something in terms of the prevention programs. There has to be an increase, and each of the first nations in the areas have to define those things.

Looking at number 5, the cost is high. It alienates the first nations. We would prefer political intervention between the minister and the government, to save the government a lot of money in the end.

What we see happening with child T whom I mentioned there is that he's going to come back and then the healing will begin within that community, because that child will never ignore his roots. It might be all right now that he is in a home until he gets to age 8 or 9, but then one day he's going to ask where he comes from.

We're looking at things in a different way, but right now we can't get around it, because that's what the law requires. We would rather have approaches that are more appropriate and less costly. The figure I mentioned, the conservative cost estimate, was \$500,000, but did we really solve the problem?

The Chair: I regret that we're out of time, but I know the committee wants to thank you for coming down. We wish you a safe flight home.

1730

INSTITUTE FOR THE PREVENTION OF CHILD ABUSE

The Chair: I call on Ms Anne Telford. Thank you for allowing us to shift you around on our schedule.

Ms Anne Telford: You're quite welcome. I'd hate to see somebody miss his plane.

I should ask that you not be alarmed by the quantity of the material. In fact, the brief itself is very brief. It was one way of supplying some information to the committee on the institute and giving you an overview of the work that's undertaken there.

It was useful for me to be here and hear some of the presentations on Better Futures, because what the people involved in the Better Futures programs are describing is

what appears to be, at this point in time, a successful implementation of real prevention at a community level, and that's very encouraging. The other advantage in that is that because those programs, for the most part, have evaluation built in at the outset, we may have a real opportunity, maybe for the first time, to have some kind of understanding of the effectiveness of prevention programs.

The reality is that we don't have a very good overview of the effectiveness of intervention programs. Indeed, we don't have a very good overview of the incidence of children who are at risk, indeed children who are abused in this province or in this country. We're hoping we will have some better information very shortly, with the release of the Ontario incidence study in mid-June. We will for the first time have some baseline data, which won't really become information for us until we've been able to replicate the study, maybe a couple of years down the road, but it is the first baseline we've had. We've had to borrow, in the interim, from our neighbours to the south and extrapolate from their data, and I expect we will see a slightly different picture in Canada.

The brief is indeed brief. What I attempted to do was identify some of the key pieces of information that are baseline information, things some of you may already be aware of, but that would support a rethinking of the way in which we currently supply services and the way in which services are accessed.

Each year in Canada, 225,000 children are abused. This is not a new number. Indeed, that may be an underestimation. We also know that for most of those children the incidence of physical abuse, neglect or sexual abuses occur while they are in the care of their parents or other caretakers, so we're talking about the younger end of the age spectrum of the child population.

Over 50 child deaths each year are known to be the result of child abuse. Again I would stress that that's known to be the result but that the number may be higher than that. As a country, we have a very bad record among industrialized nations for child deaths as a result of accidents. We do not have a good report card in that regard.

The documented consequences of abuse include cognitive and language disorders, low self-esteem, lack of trust, low frustration tolerance, poor social relationships, difficulties in school, learning disorders, and self-destructive behaviours, including substance abuse, suicide attempts and self-mutilation.

Costs of our intervention services have increased steadily and noticeably over the last decade. What tends to happen with the increased costs of those services, and then inability to supply the funds for mandated organizations to realize their mandates, is that the definition of what constitutes abuse or that which requires service becomes narrowed and organizations then are in fact serving a smaller percentage or the most extreme cases in the population.

Given all the consequences of abuse, one of the things we must do as a province, indeed as a country, is to consider the cost to us in the long term and the cost to the workplace in lost productivity. We can estimate that

that's likely in the millions of dollars. The Americans have done some evaluation of that, and they calculate that they lose \$1.3 billion annually as a result of child abuse. Now, it's rather risky to bandy a number like that about, because one would have to look at what exactly they were measuring there. It could include the costs of intervention as well as the cost of supplying education to people who have been damaged, special education services, health services, and then loss of time in the workforce.

But the message there that's pertinent to all of us is that there is an economy in considering other approaches, and that very much will affect the future of all of us. If we are heading for a workforce that is damaged, or if a large percentage of that workforce has experienced damage, then our country ultimately is not economically viable, nor are those of us who are not children likely to be particularly well supported and cared for in our old age. That may be another fact to hang on to.

The Ontario government has very good data on poverty and we have good data on that nationally, so the following information is a somewhat random selection. One in nine families with children were categorized as poor; that was three years ago. One in six Canadian children is categorized as being poor. We know that over 50% of the total workforce includes families in which both parents work, and for single parents that figure is a lot higher. There's a shortage of day care spaces to accommodate the needs of children of working parents. Day care spaces represent a form of stability for children in families that is terribly important in children realizing their developmental capabilities.

I mention the Children First document here. Although it's three and a half years old, there were indeed recommendations contained in that document that are pertinent today, perhaps most saliently the recommendation that there be a clear focus on children as a political agenda in this province and that it be a child-centred approach taken respecting children's entitlements, that that would be central to an agenda that would be a public one and a publicly supported but government-driven one.

Actually enacting that form of recommendation has the risk of turning social policy on its ear. In fact, we would almost be forced to rethink the way we develop and implement our social policies. If they were truly child-focused and centred on children's entitlements with an eye to our future, we would be engaged in a very different process.

The recommendations included in the brief are at the beginning, the primary one being that there be a public child-focused agenda incorporating a shared vision of the entitlements of children and clearly establishing children as the priority in the formulation of social policy and program development. We really haven't had that, or we haven't had that in an integrated way. It has been the focus of some specific services, of some specific ministries, but there hasn't been a broader-based agenda that's been child-focused in the past.

We also would recommend that an Ontario child and youth authority be established. This is a recommendation that evolved from some work that has been done

collaboratively with the Institute for the Prevention of Child Abuse and the Ontario Association of Children's Aid Societies. Again, the thinking there is that we need to be investing our money in a different place on the spectrum, ie, at the prevention end of services, in a way that empowers children, families and communities to realize some of the goals that were being described under the Better Futures programs, that form of empowerment and that form of catalyzing communities as a natural resource.

The concept here is that the authority would work with other ministries—and I do realize that goes on already—to address the barriers that inhibit and prevent collaboration or integration of services between ministries. The authority would ensure that resources are equitably allocated and available to all children and youth in Ontario who require them. The provincial authority would mandate and fund local authorities to bring communities and agencies together to meet the needs of children and youth in Ontario.

1740

There would also be local authorities that would involve children and youth along with community leaders, community agencies and consumers of service in the planning, development and evaluation of services to all children and youth, and we would see those operating throughout the province.

We also recommend that a plan to end the ravages of child poverty be articulated with a timetable for realization by the end of this decade, which also fits in with this country's responsibility in our ratification of the United Nations charter of rights for children.

It's also recommended that prenatal services be expanded. We've done a great deal to develop our prenatal services, well-baby clinics, services to pregnant women, but they still tend to be a bit erratically available and are not always accessible to the people who need them. I'd like to see those expanded to reduce the risk during pregnancy, those risks that have long-term negative effects on the developmental capacity of children.

Also, it's recommended that direct supports be supplied to families, particularly new parents, to promote the wellbeing of and reduce the risk of abuse to children. One of the programs or services that was mentioned here was that of home visitation. There are certainly experiences in other parts of the world of the effectiveness of home visitation programs. Hawaii, of all places, actually has an extremely effective program, and it was sort of a pilot. It's one of the states that implemented that program. One of the effects they were able to measure was a 30% reduction in the incidence of child abuse, and that's notable and certainly worth paying attention to. It means involving at the outset young parents, new parents and parents who might be more at risk, to ensure that you are in touch with that segment of the population that may have some greater needs for support.

Also, it's recommended that a plan be developed and implemented to ensure that the preschool population has access to high-quality day care; a great deal of work has gone on in this province and I'm optimistic that this continues.

Also recommended is that a promotion-prevention fund be created to facilitate the development of strategies aimed at reducing the insupportable costs of intervention as they are today, and enhancing the health and wellbeing of our child population through primary prevention and early intervention programs.

It no longer makes any sense for us to continue as we have for the past several decades, actually; I've been around long enough to remember that. There is certainly a rethinking going on. We've begun as a population to share a concept of what prevention means and what that actually looks like when it's put into practice, and we now have some good examples in our midst.

It is recommended that it's time this is happening in the population. Government is currently in a position of knowledge, at least, about the needs of this population to take a proactive stand in redirecting some of our energies to prevention services in communities. I'd like to make myself available for questions.

The Chair: Thank you very much for all the material you provided, and also for the eight recommendations you've made. At the outset, I'd ask you a question on the recommendations. These are from the institute itself, not just yours?

Ms Telford: They're from the institute. I should add that some of them actually have been developed with other organizations over a period of time.

The Chair: You made reference to Children First, and last week we had the Premier's Council here. In what you've said, what's in Children First, what the Premier's Council report says, there's certainly a lot of similarity. Do you see the Ontario child and youth authority, that you have set out here, as being a non-governmental agency, or how is that constituted? What is its relationship with government?

Ms Telford: We would see it as a way to reallocate some of the current resources. There would be a central body, a government body, within the civil branch, and the development of local authorities as well. The central body would probably have the function of facilitating resourcing the local groups, but those local groups would also have to have representation from all segments of their community, the sort of representation we heard described here in the Better Futures programs, so they have some consumer-driven element.

The Chair: Who would name the people to this authority you're proposing? Would that be done by the government of the day or would it be like a district health council?

Ms Telford: As in an appointment? I think what would be most delightful is if that were occurring within communities, because of the differences from one community to another. Certainly within this province there are cultural differences within communities. You would want to ensure that there was a very strong community involvement in that kind of decision-making.

Mr Ron Eddy (Brant-Haldimand): Thank you for your presentation on this important matter. Following up on local authorities, a few years ago there were a number of children's services committees established across the

province as pilot projects with the view that then all municipalities would have them. You'd be aware of them. Is that the way you see that? Would that work and is that the way to go?

Could you also comment on the matter of the children's and family service bureaus. It's been mentioned on occasion that community and social services departments and CASs should be combined in some way so that the segment serving youth would be together, because there are on occasion some problems, as I understand it, between the CASs and local social services.

Ms Telford: You're talking about the relationship between child welfare organizations in the community and the ministry body that interacts with them?

Mr Eddy: Yes.

Ms Telford: Well, I think that's the nature of life.

Actually, you asked me two questions. The first one was about the children's committees in communities. I was involved in those a few years ago when they were being formed. I think the intent of the process was honourable and good, and in some communities it worked well and in others it didn't. There's probably well-documented history of that experience.

Something that hadn't occurred perhaps quite so clearly at that time was the beginning of a shift in thinking about how services might be provided and what was needed. In the last few years we've moved towards more holistic approaches—to use the language of the last presenter—and paid more attention to real involvement from the community. Rather than simply a shifting of responsibilities among the service delivery agencies, we've looked to create real connections with people who receive services so they do have an active voice in that. That's occurred fairly dramatically and has continued, so the model of children's services committees as it was attempted to be implemented a number of years ago would not happen in quite the same way, but you would certainly want representation of children's services providers.

Your other question was about strain in relationships between child welfare services and government.

Mr Eddy: And municipalities.

1750

Ms Telford: That may be a trickier question. When you talk about child welfare services, you're talking about services that have been around for 100 years and more. They are well established, the services that probably have the most financial support in this province, probably in this country. They have the mandate to intervene where other services don't.

I think the nature of the strain is that there's a boundary there where there will always be some kind of conflict. I wouldn't suggest that is going to disappear overnight—some of it's very healthy—but we certainly need, together with child protection or child welfare services, to rethink the effectiveness of the way in which we spend our money. If you're asking if I believe those organizations should be divested to the community, I would say no.

Mr Eddy: Conversely, should the CASs have the

mandate to administer welfare funds for children and families? Should it go the other way? Should the children and family services' mandate be broadened and include the financial support that is supplied by community and social services in municipalities?

Ms Telford: Quite frankly, I would be concerned about locating a lot of power and financial influence within one agency.

Mr Hope: I like your idea. Some people refer to it as the human services board rather the child and youth authority. One question I must ask is, how do we break down all these walls? You're talking about different agencies, you're talking about boards of directors, and during the good economic times we were all sitting here saying: "What problem can we discover today? What money can we go after from the government, to receive funds to run a program to help these people in our community?" Now we have walls established and nobody wants to move and nobody wants to give up turf. You've come up with a great idea, but I'm speaking from experience. Trying to get some of those walls down is darned difficult.

Ms Telford: Yes, so am I. I have a lot of bumps on my head. I've been in this business a long time.

You're describing also an inevitability of organizational life. However, the reason I say the timing now is better than it ever has been—or certainly better than it has been for the last 25 years, because money has been available—is that people have experienced a lot of pain in attempting to provide their services and in attempting to sustain their organizations and, maybe most of all, in maintaining their sense of integrity in what it is they're doing, their integrity about themselves in delivering their work.

I agree that yes, there are walls, there are certainly turf wars that will be inevitable. But communities are asking to be involved. I think we see more real cooperation than ever before and we certainly have a very different piece in the scene when we have families and children having a voice. That's why I think it's critical that the first aspect of the recommendations must be realized. That's very much something that government is empowered to do, to have a children's agenda that is very clearly articulated and that will drive some of the other activity.

Mr Hope: But how do you establish a clear children's agenda when different communities have different priorities to deal with? Listen, I wholeheartedly support what you're saying about authorities. Every time I mention it the agencies get all worked up and say, "Uh oh, here comes Randy." The bells go off and the contentious issue sheets come up to Toronto and Randy's created another war with all the agencies.

I'm looking at \$1.3 billion as being allocated between children's welfare, children and family intervention, children's treatment, young offenders, children's development, community supports and child care, and that's all talking about children and youth in those areas. Kent county is a little different from Metro, but—

Ms Telford: It's also talking about intervention. What you're describing are intervention services. All those services are intervention; they're not prevention services.

Mr Hope: But in order for us to get to prevention, we must know what intervention is all about in order to establish prevention. That's why with local authorities the prevention aspect's going to change year to year.

Ms Telford: I think some of it is public awareness activity, and that's something government's in a position to do pretty effectively; and identifying the costs of intervention, which are phenomenal, and we heard some figures cited here today. To keep a kid in residential care in this province is around \$90,000, and for a kid in a young offenders' facility it's much higher, and there's no benefit. I shouldn't say there's no benefit, but the percentage of benefit may be fairly small.

There are various activities that have to go on at the same time. One can envision that there would be an education component there, the formulation of social policy that redirects some thinking and some funds. There's certainly the voice of communities that cannot be denied at this point. Communities are anxious about the inability, often, of child welfare organizations to meet their mandates. Child welfare organizations are also saying that. They may be singing from different sides of the song sheet, but there's a message there that can be coordinated and heard. I think you have to maintain your idealistic position and go on fighting the fight.

The Chair: Thank you. We are about to be called to the House for a vote. I apologize to Mr Martin, who wanted to ask a question, but to make sure we can get there, we're going to have to bring this to a close.

Thank you very much for coming before the committee, for your presentation and also for the material you brought. I also wish you all the best in the fund-raising initiative the institute is in the middle of, or at the beginning of. We're very much aware of how important the work of the institute is in this province. Thank you again.

Ms Telford: Thank you for inviting us.

The Chair: Members of the committee, as you know, next week the Legislature isn't sitting, so we will reconvene in two weeks' time, on May 30 at 3:30. The committee stands adjourned until that time.

The committee adjourned at 1757.

CONTENTS

Tuesday 17 May 1994

Children at risk	S-1503
Better Beginnings, Better Futures	S-1503
Jassy Narayan, project coordinator, Guelph	
Gary Zuber, volunteer	
Nancy Beauchamp, part-time community visitor	
Andrea Robinson, volunteer and in-home visitor	
Clara Akinsemoyin, volunteer and in-home visitor	
Brenda Lee Lowes, volunteer	
Lisa MacLean, volunteer	
Moe Brubacher, executive director, Wellington County Family and Children's Services	
Suzanne Flanagan, project coordinator, Kingston	
Leslie McDiarmid, project coordinator, Ottawa	
Dilico Ojibway Child and Family Services	S-1513
Wally McKay, consultant	
Institute for the Prevention of Child Abuse	S-1517
Anne Telford, director, prevention and information services	

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

***Chair / Président:** Beer, Charles (York-Mackenzie L)

***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

***Carter, Jenny** (Peterborough ND)

 Cunningham, Dianne (London North/-Nord PC)

***Hope, Randy R.** (Chatham-Kent ND)

***Martin, Tony** (Sault Ste Marie ND)

 McGuinty, Dalton (Ottawa South/-Sud L)

***O'Connor, Larry** (Durham-York ND)

***O'Neill, Yvonne** (Ottawa-Rideau L)

 Owens, Stephen (Scarborough Centre ND)

 Rizzo, Tony (Oakwood ND)

 Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Boucher, Joanne, research officer, Legislative Research Service

C-470A
10-2
- 577



S-53

S-53

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Monday 30 May 1994

Journal des débats (Hansard)

Lundi 30 mai 1994

**Standing committee on
social development**

**Comité permanent des
affaires sociales**

Children at risk

Enfants en situation de risque



Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Monday 30 May 1994

Lundi 30 mai 1994

The committee met at 1542 in room 151.

CHILDREN AT RISK

Consideration of a matter designated pursuant to standing order 125 relating to children "at risk."

The Chair (Mr Charles Beer): Good afternoon, ladies and gentlemen. The standing committee on social development is again meeting under standing order 125 to review a designated matter, which is the issue of children at risk. We have a full afternoon of witnesses.

Just before asking the first representatives to come forward, I note that Joanne has circulated the summary of the committee's hearings to date on children at risk. Is there anything you wanted to say about it, Joanne?

Ms Joanne Boucher: Not on that, but just to note also that we've included the report that came out last week from Metro Toronto called the Outsiders, which is on relevant issues, I think, and also a series of press clippings on relevant issues.

The Chair: Fine. Thanks very much.

ONTARIO ASSOCIATION OF

CHILDREN'S AND YOUTH INSTITUTIONS

The Chair: I call our first witnesses for this afternoon, from the Ontario Association of Children's and Youth Institutions: Maria Berton and Nancy Peters. We're delighted that you could join us today.

Ms Nancy Peters: Thank you. We're delighted to be here. I'm Nancy Peters, executive director at Massey Centre for Women. Maria Berton is the executive director for The Boys' Home. We've been asked by OntChild, as OntChild member agencies, to present to the committee the prospectus of the children whom OntChild represents.

Within the OntChild network of agencies, "risk" has been defined as the significant probability that a young person receiving services from an OntChild agency would develop serious behavioural problems or psychiatric disorders as a young adult; secondly, be dependent on social assistance and live in deprived, often abusive social and economic conditions.

OntChild agencies are providing a wide range of programs to reduce this risk for thousands of young people in Ontario. OntChild believes that young people are our future and that the needs of young people must be a priority for government and for society at large.

In spite of the fact that many initiatives have been undertaken to address the needs of our young people by all government parties, the unfortunate reality remains that young people and their concerns are not a priority

and that all too often their needs are placed on the back burner.

As stated in Children First, there must be a commitment to ensuring that all children are provided with the essentials of adequate care so that they may have the chance to realize their potential and develop into healthy, contributing members of society.

OntChild is dedicated to enhancing the quality of care provided to children and youth in Ontario. We urge the government to make children's needs a priority and to recognize that investing in services for children and youth is of critical importance to our society, not only in the short term but, even more importantly, as an investment in the long term.

What is OntChild? OntChild is a non-profit, charitable association. Its member agencies serve children and youth in both residential and non-residential capacities across all regions of Ontario, from Windsor to Cochrane, from Thunder Bay to Cornwall. Under the OntChild umbrella, agencies provide essential services to over 10,000 youth annually. In addition, OntChild serves thousands of youth in street outreach programs and in drop-in centres, in families and also hundreds of infants of the teen mothers in our maternity homes. The OntChild system treats, supports, teaches and rehabilitates youth aged 12 to 21 years.

Each OntChild agency provides a community-based service that has been instituted by local initiatives to meet a community-perceived need. Local boards of directors oversee the programs to ensure the unique and diverse flavour of the community it serves.

OntChild's youth: The combination of serious stressors and social and economic adversity faced by OntChild clients increases the risk of long-term negative consequences in OntChild's client population. OntChild's youth are at a high risk of developing serious behavioural and/or psychiatric problems.

OntChild's youth are at a high risk to become dependent on welfare and they often live in deprived and abusive social and economic conditions.

Typical OntChild clients suffer from a large number of serious stressors in their lives, adding significantly to a high level of risk. Forty-four per cent of OntChild youth suffer from a history of physical abuse; 36% of OntChild youth suffer from a history of sexual abuse. The typical OntChild client lives with poverty, mental illness and violence; they are victims of social and economic adversity. Fifty-four per cent of OntChild youth or their families are supported by welfare; 34% of OntChild youth or their families live in public housing; 28% of OntChild youth

or their families live in a single-parent household.

OntChild agencies provide residential and non-residential care to clients from a normalized, not pathological, perspective. At times, government legislation such as Bill C-120 creates additional hardship for young people, as in this case agencies will not longer be permitted to assist their clients who may be attempting to control violent partners and violent family members from whom they are trying to escape.

OntChild agencies recognize the needs of its female clients from a social, learning and growth-oriented viewpoint, not from a pathological or illness model. OntChild agencies work with female clients to provide social support, education and retraining. OntChild agencies recognize the needs of its male clients to receive structured, corrective, behavioural interventions.

OntChild agencies provide these services through a voluntary system of help rather than a mandated one. As research has shown, youth approached outside the corrections/policing systems are more likely to respond more effectively to intervention. A reference for that point is Michael Rudder in *Changing Youth in Changing Times*.

OntChild's service model treats its clients with a non-labelling, informal and cost-effective approach to intervention.

1550

In the document we've circulated for you, there are a number of graphs which indicate different perspectives of OntChild youth. They include indicators of long-term risk by gender, indicators of long-term risk by age group, indicators of long-term risk looking at females only and, again, social and economic stressors showing the percentages of OntChild youth who are impacted by various kinds of stressors in their lives. Many of them, it's important to note with this graph, have more than one of these stressors. It's not just that one youth will have one and another youth will have another; there are usually multiple stressors in their lives.

I'll now pass on to Maria Bertoni. She's going to review some of the recommendations we're making in our deputation.

Ms Maria Bertoni: Prior to beginning, I'd like to point out that there are some typographical errors on the recommendations. We will be submitting a revised copy.

We have four recommendations which we believe have picked up all the points that Nancy has made.

The first one: The direction of current thinking is the notion of partnership and collective ventures among agencies. This is reasonable, but should not be exclusive. An organization should freely have the option to pursue service directions without risking rejection because it is not a collaborative, multiagency venture. The ideology of collective versus individual approaches must not be the determining factor in defining the way services are or will be evaluated. Evaluation must be based on the ability to demonstrate the delivery of effective and efficient services to children at risk.

OntChild's recommendation is to permit and find acceptable a variety of approaches to service delivery

which recognize and support the individuality and uniqueness of all youth.

Point 2: Further research and studies are not required to confirm our knowledge that those people caught in the repetitive cycle of poverty and choice limitations are a marginalized group. Intervention must begin at the prenatal stage and continue up to transition age, which is 18-plus.

OntChild's recommendation is that prevention in the form of early identification be given priority in the form of service and funding commitment, as stated in the Ministry of Community and Social Services policy framework and the Premier's Council report entitled *Yours, Mine and Ours*.

Point 3: Two words need to be side by side, "opportunity" and "responsibility." Our aim has to be the support and encouragement of an independent and productive lifestyle. From a broad-based perspective, all services have to be responsibility-based, with built-in criteria to support and advance this direction.

OntChild's recommendation is that existing services and new initiatives clearly demonstrate their built-in criteria from the perspective of promoting individual responsibility rather than dependency-based services.

The last point: Money for new initiatives is in the direction of community-based programs. However, there continue to be community services dependent upon fundraising dollars, which places these services in jeopardy. Governments have to consider correcting the existing inequities prior to or in concert with new dollars for new initiatives.

OntChild's recommendation is that the different levels of government take the necessary steps to address and correct existing funding inequities for community-based services while continuing to promote new initiatives.

At this time we'll receive any questions that people would like to present to us.

The Chair: Thank you. Could you just refresh our memory? Bill C-120, which is a federal bill: What exactly does it do?

Ms Peters: Bill C-120 is the provincial document that has just had third reading regarding basement apartments and amendments to the Landlord and Tenant Act.

The Chair: Okay, sorry, so it's the provincial bill. It's just that C usually indicates Canada.

Ms Peters: Oh, does it? Okay. Bill 120.

Mrs Yvonne O'Neill (Ottawa-Rideau): I have quite a few questions. I'd like to ask you, because you didn't spend much time on your charts, what you mean by "risk scale" in all of your charts. You've got "parental acceptance." What are your criteria for the term "risk scale," which appears on all of the charts?

Ms Peters: The one where it says "Indicators of Long-Term Risk"? Is that what you're asking?

Mrs O'Neill: I think I can understand the other terminologies, but I'm not sure, since the whole thing is "Indicators of Long-Term Risk," what "risk scale" means. Is it a summation of all the others?

Ms Peters: Risk scale?

Mrs O'Neill: Risk scale, third from the right.

Ms Peters: You're asking the question, what does the scale mean, from zero to five?

Mrs O'Neill: What the risk scale section means, yes.

Ms Peters: As far as I understand, it's the number that's been chosen on a scale of zero to five. It could be a scale of zero to 10. It's just indicating population numbers that would have all of these risks by number. So if you're looking at social impairment—

Mrs O'Neill: No, I'm not looking at social impairment or behaviour misconduct or any of those others, because I think I understand the terms. But within each of them there is, third from the right of the page, the term "risk scale." Is that a summation of all the others?

Ms Peters: Oh, I see where you're looking.

Mrs O'Neill: Maybe you can get back to us about that.

Ms Peters: I think that we'll have to get back to you, because this came from the association.

Mrs O'Neill: Okay, if you can get back to us when you send in the correction on the recommendations, that would be great.

The Chair: Are these indicators from the Ontario Child Health Study that was on indicators of risk, the one that Dan Offord did? Where did these specific indicators come from?

Ms Peters: They're from a document that OntChild prepared called Risk in Perspective. So they're OntChild. It was a document that was looking at the youth that OntChild was serving and the kinds of risks they had when they were presenting in our agencies. We could actually include that document, if that's helpful to the committee.

Mrs O'Neill: I think that would be.

If I may go to the recommendations and your recommendation 3, would you explain a little bit more about what you mean by that? It sounds quite helpful. If you would just tell us exactly what you mean.

Ms Bertoni: What we're attempting to say with point 3 is that all services ought to have an objective in which the youth will no longer be required to depend on that service.

The essence of point number 3 is that what we believe in is that services ought to promote and inspire independent-type behaviour, as opposed to dependent behaviour. So whatever it is in the type of service that is given, it has to promote the fact that this youth will not longer continue to require services. So the essence there is that basically what we're saying is that we want that individual responsibility and to promote independent, self-sustaining behaviour, which is what a service should fundamentally have. Does that make sense?

Mrs O'Neill: That's helpful. If you would go back to your opening remarks, I have somewhat the same concern as you that the children's services are on the back burner. Could you tell us why you personally think that's the case? You work in the field every day. You must have some ideas in your own mind about why that reality—I think it's a reality; you've stated it is a reality—exists.

Ms Peters: I think one of the reasons it exists is that we're all working within difficult times. So there are financially difficult times. There are the children whose parents, because of the recession, are receiving less than adequate food and they're living in poverty and they're living in situations of violence. It's very difficult to address those concerns when the quick fix would be to say, "Yes, everyone needs to have x number more dollars and life would be easy for them," but I think we can't lose sight of the fact that when working with these children, those kinds of living situations really impact, long-term, negatively on them.

It creates a sense of dependency on systems. It creates a sense of hopelessness in being able to move forward into the future not only for the children but also for their families. I think what we see on a day-to-day basis is that there is a sense of hopelessness and a sense of not being able to get out of the cycle that they're finding themselves in and I think that puts them at greater risk.

1600

Mrs O'Neill: I guess I'd like to reiterate the back-burner concept here. Children and children's services seem now to be less important in government or in government priority-setting. That's a great concern to me. That's one of the reasons we're doing this study right at the moment. Maybe you would like to give us your opinion about why you think that's the case.

Ms Peters: I think there are a number of initiatives that could make things better for kids. There are a lot of people who, for example, are waiting for child care for their children, and there aren't enough child care subsidy dollars for kids to be in the day care system, for example.

Looking at a back-burner situation for me in my own situation at Massey Centre, the program that's providing innovative new ways for young single mothers to break out of poverty and welfare, to go back to school and to learn how to care for their children, has just been altered. The capability of running that program has been altered by legislative means. I think that's a very serious situation. There was an opportunity for young mothers to break out of this cycle which has been impacted on by a government decision. That's just an example.

Mrs O'Neill: Could you give us the actual piece of legislation you're referring to?

Ms Peters: Bill 120.

Mrs O'Neill: How does that directly affect what you were doing?

Ms Peters: We used to be exempted from the Landlord and Tenant Act, so we were able to have house rules and monitor the babies' development and teach the mothers how to care for their children by going in and working side by side with them. Now, in order to do that, we'll require 24-hour notice. If we hear that there's a situation where a child may be in difficulty from a security standpoint, we won't be able to access, which we do immediately now. We will have to call police or the CAS. It does impact on the relationships and the kinds of changes you can make for young families to experience life differently.

Mrs O'Neill: Your program was one where you had

residential care, but it was beyond. It wasn't in any one location. You were in a supportive housing situation.

Ms Peters: It's a transitional supportive housing model providing care for young mothers postnatally.

Mrs O'Neill: I'm glad you brought that to our attention.

I just have one final question. I wondered if you would be a little more explicit about when you were suggesting that you do not have—I just wanted to get the exact words here—the pathological perspective but the normalized perspective in your treatment. Could you summarize or give an example of what you mean by that approach, which I presume both of you use?

Ms Bertoni: From my perspective, you work with the youth not from the standpoint of the pathological, meaning the sick way, a sick model, but rather from the healthy model. It's a different slant on how you work with kids than the previous model.

Mrs Dianne Cunningham (London North): Thank you very much for being here. What city are you from?

Ms Peters: Toronto.

Ms Bertoni: Toronto.

Mrs Cunningham: My perspective is more London, Ontario. I was listening carefully when you talked about Bill 120. I have to tell you that there were many presentations before the committee making the point that you made, and the government just ignored it. I think you should try it again, give some specific examples in the next six months and don't leave it, because if you're trying to get in and help people and they're using this as an excuse for allowing you to be helpful, I think those kinds of things have to be documented. Make sure you let us know about it.

Ms Peters: Certainly I'll be presenting at an OntChild conference this week about the bill because it's not only Massey Centre that's impacted; it's a number of OntChild agencies. We will be looking at that and I'll take those words back. It's very helpful.

Mrs Cunningham: If you've got specific examples, don't wait too long. One or two are enough. That's what everybody needs to hear.

When you talk about children at risk, and I certainly agree with and appreciate your definition, are you basically dealing with young children in your work and are you dealing with a lot of volunteers? When you talk about funding, what kind of funding for what kind of programs are you talking about?

Ms Bertoni: From an OntChild standpoint?

Mrs Cunningham: Yes.

Ms Bertoni: It's youth ages 12 to 18, but it's also young moms and their babies. From a funding standpoint, pretty well all services are receiving money from Community and Social Services, from the ministry. There are some fund-raising dollars as well, but primarily our revenue comes from the Ministry of Community and Social Services.

Mrs Cunningham: These are programs that are specific to Toronto and area?

Ms Bertoni: These programs are province-wide.

Ms Peters: The province-wide programs would receive funding through the Ministry of Community and Social Services. In Metro we also receive some Metro dollars for our child care portions.

Mrs Cunningham: How much work do you do with the local school systems?

Ms Peters: A number of OntChild agencies have section 27 schools attached to the agency, usually joint partnerships with whatever their local school board is. As well, the agency would do the general administration for that school program.

Mrs Cunningham: Do you find that there is a freedom of information flowing between your agency and the teachers or are you finding that the teachers are hesitant to get involved with the work that you're doing with the students?

Ms Bertoni: At The Boys' Home we have a section 27 classroom and under the current regulations the teachers are helpful. However, we are not permitted to give information on the kids or their backgrounds. Respecting that limitation of information, we have found the teachers to be rather helpful. Most of The Boys' Home kids are in our section 27 or in local schools, and we've not had a problem with integrating the kids in the local schools and receiving support, providing whatever direction is necessary.

Mrs Cunningham: I mean, 12 to 18 is late to do some of the things I know you want to do, right? The reason I'm asking the question is because, certainly in my travels and in my position as the critic for Education and Training, I'm finding that with a lot of the agencies such as yours, there isn't the kind of free flow of support that each needs to do its work, because of too much red tape and legislation. A lot of the programs probably would be more beneficial if they extended before and after the school day.

Ms Bertoni: On early identification, what we're trying to raise there is the point that with children at a much younger age—and this goes back to day care—there are problems which are identified. If those problems are adequately dealt with at a very young age, they'll require the kind of services, for example, that The Boys' Home has. We're making an emphasis to identify early and provide the remedial assistance required, and more than likely the kids won't be needing the residential care that Nancy has or that I have or that other agencies have.

It's kind of putting it up front at that age. We say here "prenatal" clearly for a reason. If young moms have the support, have the knowledge, have the education they require, then there's a very good chance that they'll do much better, their kids will do much better and they won't have to look in my doors.

Mrs Cunningham: The neonatal physicians would agree with you too, for a lot of reasons.

On your last page, page 5, you talk about research, which I don't believe we use to the extent that we ought to in Ontario. "As the research has shown, youth approached outside the corrections/policing systems are more likely to respond more effectively to intervention."

You work with young people, young boys, you talked about The Boys' Home. Can you give us any examples here of the kind of work you do that would support this recommendation, which is really saying, "Better they be outside penal institutions," either in schools or in programs such as your own? I think that's what you're saying here. Can you help us in that way? Do we need more of the programs that you're talking about—my assumption is yes—and why?

Ms Peters: It's all a part of what we were talking about in the comment about normalizing behaviour. By providing programs such as we're providing, the services are able to meet the kids where they are when they present to us and then begin to build on the kinds of needs they require rather than addressing only the behaviour that got them into a penal institution of some kind.

By front-ending with agencies such as ours, which are teaching them how to interact socially, how to go back and get an education, making them feel hopeful that they can be successful, that they're not "bad kids," is really an important aspect of what we're doing. Rather than getting caught up for these kids believing, "Okay now, I'm in an institution because I've been a young offender," it's creating a different life outcome for them.

Ms Jenny Carter (Peterborough): I've just got one or two points of clarification here. On your first graph, prior placements, does that mean that sometimes children have been in an unsuitable placement and that has become an additional stress? Is that why those are there?

Ms Peters: Yes, that's correct. A number of OntChild children have been in more than one placement and the placement has broken down. That increases stressors because they have to become acquainted with different ways of doing things in different agencies, or they've come into one agency for some problem and they've gone back home and the family situation breaks down again, so they are placed in another kind of institution. They have a number of changes in their lives.

Ms Carter: You do have living in public housing as a risk factor. That puzzles me a little bit, because presumably somebody in public housing is better off than if they had something worse still.

Ms Peters: I think it's all comparative. In looking at where this information came from, living in public housing was a very common thread for the children we were reviewing when we were looking at kids at risk and, from their perspective, public housing seemed to be a common denominator that a lot of them had.

Ms Carter: One would need to know whether that was because certain people end up in public housing or because it was ghettoized in some way.

Ms Peters: Or because it's related to living with a lower income than other families have, which could be one of the strong indicators.

Ms Carter: I just wondered in the last graph in the bundle here why there are two different kinds of hatching, whether there's any significance to that. That's the social and economic stressors.

Ms Bertoni: Sorry, two different kinds of?

Ms Carter: You've got the sort of loose striping and then the closer striping, and I'm just wondering—

Ms Peters: It's because one is looking at the economic stressors, the ones at the top, and the bottoms are—

Ms Carter: And the bottom's the economic, okay.

Ms Peters: It's splitting off separately.

Ms Carter: Yes, right. That makes sense. I'm concerned about what you're saying about Bill 120. I find it a bit puzzling, though. I can't believe that access would be denied in a case of emergency, and of course in this government we have gone through the Advocacy Act, which by definition is something whereby somebody who needs help in an emergency can get that response, and if entry were not given immediately, then the advocate could get a warrant and could gain access. I'm just wondering what the real situation is here.

Ms Peters: For Massey Centre and for a number of OntChild agencies the real situation is that when we were exempted from the Landlord and Tenant Act we were providing programs and now, being placed under the Landlord and Tenant Act, we are in a position of providing housing. The bill has changed the perspective of what it is we're actually doing with the clients, in that prior, when it was programs that we were providing for them, we were able to have things like house rules.

One of the things we do at Massey Centre is, every client who comes into the program has to go to school or go to work to be eligible for the program. We will not be able to have that rule any more. It will just make it regular housing, whereas before, housing was just a piece of a program that we do, the same as day care and section 27 school. It changes a number of the criteria in the way we're able to do things differently for kids.

If there's a problem in one of the housing units now, we will have to call the police or children's aid, whereas before, we would just access their units and give them support and take the baby away if the baby was giving them some problems, look after the baby for two hours, and then they go back and feel good that they can manage again. It makes it a more adversarial kind of situation for us.

Ms Carter: I'm not absolutely clear about the structure of OntChild, just how it works in with other agencies. For example, in my own city of Peterborough—we have a representative right here—would you operate there, and if so, in what capacity?

Ms Peters: It's a provincial association of agencies, about 40 agencies, that are providing services to youth. So I can't say 100% certain that we have an OntChild member from the Peterborough area but we certainly are diversified all over Ontario.

Ms Carter: But do the existing agencies come in under your umbrella rather than you originating them?

Ms Bertoni: Yes. Agencies have come under the umbrella. The association was created 10 years ago and a number of agencies have joined the association and many new ones can join as well, but basically the 40 agencies that Nancy referred to have been in existence for quite a long time.

The Chair: Thank you. I regret that we've finished

our half-hour. I wonder, just because of the interest in the subject of Bill 120—you said you were going to be making some comments later this week or next week at a conference—it might be useful for members of the committee if you could send us a copy of those remarks.

Ms Peters: I will, for sure. Thank you for giving us the time to speak.

Mr Randy R. Hope (Chatham-Kent): Mr Beer, while they may be sending that, recommendation number 4 talked about inequities of funding and I'm wondering if they could maybe forward how much it does cost to service a child. Everybody bases their comments on equity funding but we have no dollar figure of what it does take to service a child. That would be important.

The Chair: If you have that answer, we'd like to have that one too.

Ms Peters: We will, for sure.

ONTARIO TEACHERS' FEDERATION

The Chair: I would then call on our next witnesses representing the Ontario Teachers' Federation, Douglas Lougheed, principal, Danforth Collegiate and Technical Institute, and Margaret Ann Lougheed, guidance counselor at Northern Secondary School. Welcome to you both. We're a little bit behind but we have the full half-hour.

Mr Douglas Lougheed: We'll try and move it along. Thank you for the opportunity to present to this committee. When we were asked by the teachers' federation, we saw it as an opportunity.

I have prepared a very brief summary, along with two handouts, one of which will give you a little background about myself, if you can read it. I guess you need a magnifying glass or powerful reading glasses to see the fine print. I apologize for that.

The second is simply an idea at the moment. It's a very well-thought-out idea on the Gateway project which deals with and really is a link between the people presenting before us and the presentation later in a way of dealing with kids coming out of detention and giving them an opportunity to develop the skills to enable them to transit back into regular schooling. We are currently on a search for funding for that project. I steal the opportunity to say that.

1620

I assume this committee would be well aware of the problems of at-risk students, because they're not really secret and they're pretty well documented. What we are looking at are solutions, all of us. There's certainly an increase in the identified number of at-risk students. We are much more aware of the behaviours that these young people exhibit and we are currently trying to deal with them in the school system.

The sources covered by the committee's mandate—poverty, living conditions and abuse—are primary factors in teenage problems. These are not limited to any part of the economic spectrum. We know that those who are living in poverty and difficult housing situations present certain difficulties, although the problems of abuse cover the entire spectrum of our economic and cultural mosaic and there is no specific group from which those problems come. I think that's important for all of us to remember.

We sometimes think of inner-city schools as being in need. I believe that all schools are in need. I've had the opportunity to work in all parts of the city—the north, the west, the east and the centre—and there is no area that is without need in these things.

In reality, the statistics point out that 3% to 4% of our youth are in serious need of treatment, the services of agencies in special treatment, while 17% are at-risk kids. We should keep in perspective that 80% of our youth are probably okay. Sometimes in things like this we lose sight of the fact that all kids are not problems and all kids are not in the same need, although they have different kinds of needs at the other spectrum of our programs.

Although we're talking on behalf of the federation, I've used examples from my own school to highlight the kinds of things that have been happening and perhaps to point out the problems and some of the things we need. I'll mention three.

Fast-tracking is a program we've recently evolved where we take kids who are seriously behind in credits, kids who are 16, 17, 18 years of age with anything less than five credits—there is a surprising number of these students—and find ways to put them in a program which enables them to move quickly through the system. They go out of the range of normal classroom scheduling, and we're expanding that into computer learning; we think that will provide a linkup. The idea is certainly used in Gateway of how we might do a better job with kids who leave school, go to other areas where similar programs could be evolved, carry a disc with them, come back into school and have a way of either catching up or staying on track and having an opportunity in terms of being a contributing member of society. Many of these kids who are in trouble have abilities that they never get a chance to portray.

Behaviour modification is a very major part of dealing with kids who come with all the things presented here, with many programs in the school using many resources: social workers, psych-ed consultants, youth child care workers within our school.

Mentoring, which has now come with a destreaming project, is very much a contributing factor to increased attendance and better performance of difficult students, and all students, in fact.

Some examples of agencies: We run a program, Change Your Future, where we have people who come into our school and work with black youth to help them to change their perspective on the world, provide role models, counsel them. Kids in that program in our school are doing very well. That program extends to other schools throughout the city.

A very new idea is one with Frontier College, which is a funded agency which provides tutorial services. I believe we're the first school to have tutors from Frontier College come directly into our school and work with young people who are slow readers. I know the public has difficulty understanding that kids who go through our school system come to high school reading at a grade 2 and 3 level, but that is a reality, and we're trying to get some increased ways of helping these kids to have a better chance.

The life skills program directly related at one time to the Boys' Home. We house the Boys' Home program at Danforth, although it's part of the hospitals and institutions, but it actually is located in our building. We have dealt with those kids for all the years I've been there. In fact, when the kids graduate, in a way, from the Boys' Home, they integrate into our school, and several of them have done so quite successfully. Two, I know for sure, will graduate this year from Danforth, so there is a continuum.

They formerly provided a resource in our school. Funding eliminated that. We also had a resource from Central Toronto Youth Services. It was a two-pronged program. When one prong withdrew, the other withdrew. Now we no longer have the life skills program, and that is fairly typical of what has happened.

These programs do work. They increase retention in school. They do increase kids' ability to learn and they are important. Suddenly we are faced with cutbacks, for reasons that have already been pointed out and that are very real. However, they're cutbacks in areas that in our opinion and in my opinion are already poorly financed and poorly staffed for the needs that are there.

At the same time there are decisions—I guess I can give specifics, if you like. In my opinion, there are many decisions made politically where tax dollars are spent on projects and programs which have little or no accountability to the general public and where people cannot show specific outcomes. In the meantime, projects where there is documentation and there are real outcomes are cut, and we find that very difficult.

In our own school this year, we have lost 10 teachers because of the changes in the factors of destreaming as opposed to basic education. Funding: We have lost a social worker, we have lost the life skills people, we've lost four educational assistants. The kinds of things you would read about in that article which are real and have good outcomes cannot be done at the same level as those resources dwindle. They are expensive, I recognize that, but we must find a way to deal with the at-risk kids in our schools because society cannot afford not to succeed with them. They are difficult, demanding and very needy young people. They are special kids and they require special adults to help them.

I hope this committee would look at ways of doing that, because it is a real, crucial situation. Margaret Ann will carry on with her agencies.

Ms Margaret Ann Lougheed: I would like to start with my answer to the question you asked of the people from OntChild: Why are adolescents not a high priority? My own theory has always been that the adolescents between the ages of 12 and 18 are the only group in society who do not affect a political vote. Under 12, children by law have to be looked after, and you don't get the vote until you're 18 years old. I really think there's a whole group in society that most politicians don't want to hear about, especially when they're running for office, because they do not create votes. That has been a little pet feeling of mine for quite a long time, and I'm just delighted to be able to get it out in a political atmosphere.

I've been teaching on and off for 34 years and during the last few years have been in full-time guidance. At the same time as I've been doing full-time guidance, I've been on three community boards, primarily dealing with adolescents. One of them, Delisle Youth Services, has counselling as well as a residential program and a section 27 program, as that is somewhat similar to Boys' Home program. They deal with a very small number of students.

The other board I have been on is POINT, People and Organizations in North Toronto, which really started to address the drug culture in the late 1960s. At that time it was called the North Toronto youth counselling project and then it evolved through many different situations, and POINT for many years has been the result.

I am the board representative to the Health Station, which was funded, and I think really quite a miracle of funding, through Ministry of Health and Comsoc working together to provide that agency. It is truly an example of government ministries working together.

Through the Health Station, Delisle is providing counselling to adolescents, but it's doing it with no funding at all. When the two ministries decided to fund the Health Station, it was to concentrate mainly on seniors and adolescents. I think I'm right in saying that it was close to \$480,000 that was provided to fund the seniors programs and zero dollars to provide adolescent services, which gives you some idea of the difference in the priorities. As a result, Delisle has been providing the counsellor one half-day a week for a crisis drop-in, and yet Delisle's funding has been cut back and they're getting no funding for their counselling specifically for that, and very little funding to their agency for counselling as it stands.

1630

As well, I'm involved with an adolescent mental health committee which is involving Sunnybrook hospital, North York General Hospital, the Health Station, Delisle and several other areas in the north Toronto area, looking at services for adolescents. What we're hoping to do is to be able to come up with the gaps in service in order to assist adolescents, and we want to look at the group up to age 24, because we feel that the transitional age group from 18 to 24 also is being very badly serviced.

We are appalled at the fact that the only agency north of Bloor Street is Delisle Youth Services, looking at counselling. We are working with them at Northern Secondary School now doing a dropout prevention program. It's been highly successful this year, and the money has come through Citizenship and Immigration. It may not be funded next year because they are now looking at a work component and they didn't really say that the money was for any more than one year.

It has been highly successful. They're working with close to 40 students, and we will be very, very disappointed if we lose that resource. Because it has been successful in keeping these very high-risk students in school, we're very much hoping that that kind of thing will continue and that this sort of program could be initiated in other schools in the same way. Reaching 40 at-risk students with two social workers is a fairly high percentage of payback.

Another thing for certainly guidance people in secondary schools, and I think we'd have to look at children's service as well, is that accessing counselling services is a real problem. Psychologists are not funded, basically, especially to people who are not on any sort of health plan, and most people on health plans don't get full funding for psychologists. Social workers are not funded unless they're in community agencies.

What you're looking at in terms of adolescents is that if you want to get counselling help for students, there is a wait of anywhere up to six months. Three to four weeks would be the absolute minimum. The tragedy is that in most cases, one or two sessions for some of these kids can set them in the right direction. It can link them with something; it can show that someone cares. Oftentimes two or three sessions will be all you need, on a crisis basis, to create an intervention that is going to stop behavioral problems which can be really quite serious in society and can have ramifications that cause an awful lot more financial penalty than the two or three sessions of counselling that might have been the intervention right then.

I think the training for physicians, psychologists, psychiatrists who are working with adolescents—physicians in particular—does not focus in on adolescent care. Of all the physician surveys we in this adolescent task force sent out, from physicians we got something like seven back, and of those, very few were answered in such a way that you would really think adolescents were a priority. So that's another area that needs to be looked at in terms of training people to deal with children and youth and the problems they are experiencing.

I agree with the question that was asked about Ont-Child. The free flow of information is a problem in terms of schools getting information from the medical fraternity. In many cases we send kids on to get help and they may be getting counselling, but in no way is the school given any direction on how we should be handling these kids. If you have somebody who has a psychological problem and you can't let the teachers know that there is a specific problem and this is how they should be dealing with it, then all the school is doing in many cases is exacerbating a problem that may be starting in the school itself. We have to in some way address the fact that we need to be able to have more information to help these kids.

The most important thing is that we have to fund existing agencies to a much higher degree than we are at the present time and look for a continuum of care between the social agencies and the schools so that we can deal with the people who are having problems and creating a problem for our society.

I'd be glad to answer questions, and I'm sure Doug would.

The Chair: Thank you for the material you've provided. We could probably spend several hours and also ought to go out, if we had the time, to look at some of the projects you've referred to. But we'll try to get some of that in the time for questions.

Mrs O'Neill: Let me start with a technical question again. You've given the figures around the 80%, and I

certainly agree with those. Are they from your own experience? Are they provincial or your own?

Ms Loughheed: I work with the adolescent mental health committee through Sunnybrook hospital, and we've actually just done a survey in the four schools in North Toronto. I actually have the study with me. I don't think it's a document Sunnybrook would want me to pass on, but the figures came out exactly the same, so this is the information I have from Sunnybrook.

Mrs O'Neill: I have some background in education and I'm very pleased that you brought forward the example of the two or three sessions that can really turn people around if they're offered at the right point. I've seen that often, and I don't think you were exaggerating at all. That's a point that has to be made.

Mr Loughheed, you mentioned destreaming, and I'd like you to say a little more. We've had very little in the Legislature about the evaluation of that program. You seem to have your own personal interpretation of how it's changing things. There certainly is a body of people who think it should be into grade 10 as well, so it would be very helpful if you could give us how it's changed the students you work with and their daily lives.

Mr Loughheed: I would answer on a personal basis. I certainly wouldn't represent the Ontario Teachers' Federation in my views on destreaming. If they thought I was going to do that, I don't think they would have sent me.

Mrs O'Neill: But the thing is you're dealing with it.

Mr Loughheed: I've had an opportunity to go through a project that has been extremely successful, for a number of reasons, and therefore I am very positive about destreaming. I will give you one poignant example, because I believe we have to have specific outcomes to evaluate.

About two weeks ago, I was talking to my vice-principal and a young girl, Vanessa. I went in and Vanessa was sitting there. I've had quite a bit to do with her all year long, a very at-risk student, in my opinion, who has used many of our resources. She had a big smile on her face. "Mr Loughheed, I'm in all advanced next year. My elementary school told me I was basic. I never could get the questions right. I get all the math questions right, I can do my English and I'm in all advanced." To me—and that's a single example; there are many others—that is really what the whole object of this program was.

I have interpreted destreaming a little differently from some. To me, it is getting away from the idea that we have three different curriculums: an advanced curriculum, a general curriculum and a basic. We have one continuum of curriculum and kids enter that curriculum at different points in time with different skills and different capabilities, and our object is to get them all as high up the curriculum as we can. That is the basis on which we started and that is really the basis on which we have operated.

I have not bought into the fact that all classes must be heterogeneous and that all levels of kids in all things must be in the same classes. I don't agree with that, because I don't think it's very practical.

For instance, in French in our school, because we were relieved of 110-hour restraints, we don't have 110 hours for subjects. French in our school is taught 30 minutes every day. We're in a two-day schedule with 75-minute periods. The academics in the morning are about 60 minutes. We have 20 minutes of mentoring. Every student in our school goes through an hour of technology and they go through the six broad-based technologies. Every kid, girls and boys, is exposed to all of the broad-based technologies throughout the year. They have semestering in art and music and dramatic arts, and there is absolutely no choice in our program.

Because of the nature of the kids in my school—you have to understand a little bit. It's not a typical school and there are places that can't do what we have done, and we may not be able to do it pretty soon if they continue to usurp the resources we've had. We have been able to maintain very reasonable class sizes. We have been able to totally integrate our special education teachers into the classroom, so almost all classes in grade 9 have a teacher of the subject plus either a special education teacher or an ed assistant in that classroom to deal with the learning difficulties of the kids.

We were the only school remaining in the east end of Toronto that was teaching basic level kids and we still retain a high number of those kids coming in, although they're not designated as basic any more. We also have 250 special education students who cover the complete range from gifted to very slow learners coming into the school. So we have a very diversified program.

I also had the fortune and opportunity to hire almost 50 teachers in the last five years since I've been there. Therefore, the staff was very committed and we reached a total consensus on what we wanted to do. The staff are very positive about the program. That also is not true of all schools in all places. So we're in a transition.

The other thing people must remember about destreaming is that we're only finished year one and it was all done backwards because of government decisions. It would have made sense, as we originally recommended as principals, to introduce destreaming in a 7, 8, 9 mode, begin in grade 7 and move through grade 8 and have kids coming into grade 9 who were part of the project, whereas we dumped it into grade 9 to start and 7s and 8s haven't caught up with us yet.

There are a lot of problems we have faced, but in our school I'm very positive about it. In fact, in grade 10 we are retaining an open-level concept in the technology. We're not going directly back to advanced-general, because we don't think that would be productive. Retaining destreaming in grade 10 in our situation probably would make sense.

But people have to keep in mind that it's a project. It has worked for specific reasons. I think those reasons are tied in with what we're talking about today, and that is providing resources that are properly used, that are accountable and where you can show outcomes. It is a massive problem to go through the whole province and provide the kind of resources I have, but then everyone doesn't have the same kind of kids.

I could talk about destreaming for a long time.

The Chair: That was a very fulsome answer. I apologize. I have Mrs Cunningham and Mr Martin. I want to make sure they have time for their questions and answers.

Mrs Cunningham: It was refreshing, I think, when Mr Loughheed said some things work in some schools and some work in others.

We all read that Toronto Star article in February—it was the Globe and Mail, sorry—with Jennifer Lewington. I must say that I was really proud to know you, and I wasn't a bit surprised. I think in this business so much has to do with people and their commitment and long hours and caring about kids, and you're a good leader.

But back to this one: Why do you think we can't have the kinds of programs you're talking about here, the Gateway Centre Project, starting from scratch? We work with the Family Court clinic in London, Ontario, but all these students we're working with are in school. Otherwise, we have storefront schools, and we have to track the students to see how successful they are. It started when I was on the school board, actually, in about 1976, and it's one of the forms of alternative schooling in London. Do you not have any of that here? You're looking for support for the project. To me, this is an Education-funded matter if they're students.

Mr Loughheed: Yes, we do have them in our schools. I'm not sure if we study how successful we are with these kids.

My experience is that kids coming back into school from detention are generally seriously behind. Their education is disrupted. It's often used in detention as a punishment, whether they get schooling or not. If they're away for eight months to a year, they're lucky if they get half a credit or a credit, and often it's a credit they already have; there's very little coordination between the two. That's where this idea started.

Secondly, they have a great many other needs if we want to keep them from repeating offences. This project is geared to a large extent to trying to provide those resources in an alternative setting.

I agree with you, Dianne, in the initial idea of the funding of the project, the teaching component, primarily, of the program would be provided by the board because yes, students do generate funds. But the other costs of the project are not funds which would currently be available under the current educational spending, certainly not in our board. We can't get enough to buy textbooks, let alone to expand a project like this and run it and rent a storefront.

It was a project that was evolved with the Clarke Institute of Psychiatry and with probation; these people have all been involved in the planning. With having a probation officer right on the premises where the kids go, and providing courses onsite in anger management and drug-alcohol abuse, which many of these kids are involved in, the whole idea of it is not to provide an alternative program, but to provide an alternative program which will enable them to come back into school on an equal playing field, because many of these kids come back not on a level playing field and they don't do well. The reasons they offend often have not been dealt with at

that time and until they are, they're probably not going to fit into regular classrooms in regular schools.

Mrs Cunningham: We've had some success with our adult day school. Again, very controversial: You'll remember the ministry pulled the funding from it. You know those issues, but we've allowed many of our young offenders to attend that school—not "allowed," they qualify for some of the reasons. It's just a point.

I think what you're really saying here is that with this collaboration, communication and continuity, the secret is to have something in place that people know about, that's been there for a good 10 years and you can look to it as a model of success.

Mr Lougheed: Just very quickly, the continuation was to have a linkage with the school, to have a storefront as well as programs in the school where there would be a linkage through the computer learning, to have kids who offend able to have their own disks which they would take where they're at, would take it to a detention centre or wherever they can find it, present it to someone there who would have the same facilities, in the ideal world, and who could very quickly ascertain where they are, plug them into the same programs which are now very good and very independent.

They don't require classroom teaching. The kids can learn by computer learning. They could progress through their time in detention, which varies from a few months to a few years, depending on what the kids do, and then when they came out, they could come back into a school and continue again on the same continuum.

These kids get lost in the system; they really do. You end up dealing with them. They get out of detention, they get into halfway homes, they get into group homes, they go to school A, they just get settled, and when their time in the group home is finished, they may go back to their own home or they may go to another group home and they change. So they change schools frequently, kids who have been in eight, 10, 12 secondary schools and if you look at the statistics and go through them, they have not been successful.

The other thing we were trying to through the Clarke was to do something we could really study and evaluate and at the end of the project say, "Yes, this works," or, "This doesn't work."

I think with so much of what we do in education and in other areas is that we pour millions of dollars after projects, but we never really have any hard statistics whether the thing really worked or whether kids were successful or whether a model group that was in the schools was the same success or less. We never really know whether it was a wise move or not, and this one, I think, has a chance to do just that, to monitor a group of kids. In terms of costs, if you study the costs of kids in these situations, if we were to make a difference in one out of four kids, the project would be paid for.

Mrs Cunningham: This school mentioned curriculum. You demand certain curriculum. For instance, you mentioned technology. One of the great complaints we're getting is that many of the students don't relate to their secondary school programs; they really want to have a

job. You're in a school where you probably do relate more to the demands of students, but many of the students are so frustrated because they want more; they want a school-to-work program. I'm talking about the students we're talking about today.

Mr Lougheed: Part of that program is that the school would be a 9-to-9 school and that was exactly that. We know these kids and they actually do quite well in work situations. If we could provide that, we would have a flexible attendance in school. They won't go to school on a regular basis. They won't be there at 9 o'clock and go to class A at 9 in the morning. That's not going to work. This would enable them to have a work component to integrate into and come in on flexible hours to take their schooling, with the proper resources to deal with them and see if that makes a difference in the final analysis.

1650

Mr Tony Martin (Sault Ste Marie): Just a short comment on the comment that the reason money doesn't go to young people is because they don't vote: I was in front of a whole auditorium full of seniors last week at home during constituency week, and they were complaining that all the money was going to young people and none to them. Maybe you can come with me next time and explain to them how in fact they're wrong.

I guess that flows into my question. It's around the issue that, in my community anyway, anybody you talk to who is in the field of trying to deal with kids at risk will tell you that there's enough money in the system; it's just that it's not being spent in the right places and that we're not willing to make the changes necessary to coordinate and have cooperation and that kind of thing.

I also believe that by simply putting more and more professionals into the field and focusing solely on programs you can't resolve this either, that somehow you have to involve the whole community, that it has to be a communal effort. We haven't been very successful in bringing other players to the table, in my mind.

I remember developing programs in a past life and being very active in trying to put something new in there that did include some preventive-type things and community-development-type things. When the program came back and the money started to flow, it was more of the same: lots of money for the professionals to go out there and do the work and not so much money for what I call the paratroopers out in the trenches working with the kids in the evenings and weekends and bringing kids forward to schools to find out what was going on.

I'm wondering if you have any ideas, any suggestions as to how we get to actually redirecting that money and how we bring the larger community into the picture.

Ms Lougheed: I think one of the big problems is that most of the front-line workers don't know where that money is. Dianne made a comment one time when I was talking to her about, "That program would fit into the Ontario training"—I'm not sure what it was. There was money in training. That's well and good, but when you're working in an agency or you're working in a school, then it's very difficult to know where the money exists. You could spend a lifetime trying to figure out which ministry

in the government had a little bit of money and if your project really fit into that.

I don't know how you fix that, but I think it would be really helpful for front-line workers to know somehow how to access it and where it is. We spend our time working with the kids and being frustrated at the lack of funding, but knowing how to access it and where it is and where that particular project would fall is almost a full-time job. That's why I think a lot of people are hiring fund-raisers and people who know about getting funds and how to write letters, because there's a real trick to it, how to fill out a proposal. There's a lot of bureaucracy that you have to get through in order to access funding.

Mr Martin: My comment wasn't so much that we should access new funds or be looking at programs. I started my comments by saying many people think that there is enough money already in the system and that it's a matter of how we get our hands on it to redirect it so that it really does become effective and helpful.

I think back over the last three years and the struggle we had to get destreaming into the system and the fight we had with those who would resist change and who didn't see it as a good thing for students. I think there is enough money there; it's a matter of how we spend it. So it's not a matter of looking for new money, in my mind; it's a matter of redirecting what we're spending.

Ms Lougheed: But that's what I meant. So many times the people who want to access the money don't know where to ask for it. There probably is money there and it could be redirected for certain projects, but I think, if you understand what I'm saying, that it's just that the front-line worker doesn't know how to access it, doesn't know where it is.

Mr Lougheed: I think there are two things. One, when we talk about professional resources, I don't think either Margaret Ann or I are referring specifically to more teachers in the classroom. Many of the solutions for these kids lie in increased access to youth workers, to people who can make contact with them and can provide a continuity in their lives, and who have skills. Those people are out there and they're a lot less expensive than a teacher, to be honest. But with these kids, they probably are worth their weight in gold and we don't have enough of them. In agency care, I think you'll find the same thing.

The other thing is that we represent secondary schooling. In an ideal world, many of the solutions to the kids we deal with do not lie at the secondary level; they lie in early childhood and in early educational times. We have to do a better job. We can't afford to have kids who are capable of coming to school reading at a grade 2 level in grade 9. We have to look to what's happened to those kids in their early years and in kindergarten and grades 1 and 2. Those statistics are out there and we have to address that, because these problems, when we deal with them, are very entrenched and they're not easily solved.

The Chair: I regret that we're out of time, but I know I speak on behalf of the committee in thanking you both for coming today and for the material you've left with us. We appreciate it very much.

ONTARIO CONTRACT CUSTODY OBSERVATION AND DETENTION HOMES ASSOCIATION

The Chair: I call on our next witness, from the Ontario Contract Custody Observation and Detention Homes Association, Mr Bob Thompson, president. Welcome to the committee.

Mr Robert Thompson: Thank you for the opportunity to meet with the standing committee. The Ontario Contract Custody Observation and Detention Homes Association, or OCCODHA.

The Chair: You should have a contest to find a new name.

Mr Thompson: That would be helpful. The name was developed about 10 years ago.

The members of OCCODHA are agencies that are, in your terminology, I suppose—I was interested in your mandate—agencies of last resort. It struck me, as I was thinking of what kind of message to present to you, that often the issues we are dealing with are not children in need of protection, but society's demands that it be protected.

I'm assuming that a number of your constituents have put that case very clearly to you. There is a great concern for escalating youth crime. There's a perception that young offenders are just little hoodlums who have figured out the system and are getting off scot-free and that society should be exerting its rights to be protected.

Those thoughts are very paramount in my mind as I sit before you today. If there is any message that I want to leave with you, it is that the youth the agencies of OCCODHA see are youth at risk. They are often victims. They are not to be excused in that status for what they have done, but there is a dual responsibility that we have as a community, and that is to protect society but also to look at the development of our youth. It's in that regard that I'm here before you today.

1700

A bit about the agencies that deal with detention programs and custody programs: They range across Ontario. There is a myth that really there are no programs that work. I want to dispel that with you.

I heard one of your members talk about her affiliation with the London Family Court Clinic. Out of that clinic, Dr Alan Leschied has been funded by the Ministry of Community and Social Services to do a review of treatment programs for young offenders. His findings, which are now published, are being used by a number of agencies across Ontario to identify particular risk factors in young offenders and to address programs to those factors. There are a number of programs that have been shown to be effective.

On the myth factor that is there, that nothing works, I would hope that in opportunities you have to deal with your constituents in that regard you would refer them to the literature and to what actually does work.

I want to emphasize the point around youth at risk, just a couple of comments. All adolescents have developmental needs. It's their job description to struggle between that dependent state and independence. My 15-year-old is in the midst of it, as I'm sure a number of

your children and relatives have gone through that. What we find is that a number of young offenders also have special needs beyond those normal developmental ones that make their development very difficult.

These kids also have personal attributes and they live in situations, in circumstances that are associated with the criminal future. Ask anyone in the field or look at the reviews of the literature: child abuse, living in situations of abuse, inadequate parental supervision, low achievement in school.

I was very interested in the comments earlier in terms of programs that have developed in one area of this province. I happen to come from another area, Thunder Bay, and there are programs between schools and community agencies there that deal with that same factor, that low achievement in school is often affiliated with future crime, problems with peer relations and anti-social attitudes. These are kids at risk.

I want to speak particularly about youth who have been victims of abuse. I am director of an agency. Within our agency we've recently done a review, and in 90% of the social histories that we read kids who've ended up in custody or detention programs have been victims of abuse by someone in authority: their parent, a teacher, a trusted authority figure in the community. They've learned, by these personal violations, that what wins is power and dominance. They just haven't been able to develop healthy mechanisms to deal with that kind of conflict.

When I mention that scenario or picture, that is duplicated in every community across Ontario. As I talk with people who operate agencies in other communities, it's the same story.

We cannot excuse their behaviour because they've been victims of abuse. There's a tendency often for people who relate this information to do it in a very pessimistic way and the impression is given that we should mollicoddle these kids. It's the last thing in the world that an effective program should address itself to. Youth need to assume responsibility, healthy development. They're becoming adults.

I was in a forum on youth crime last week that the member for our area, Shelley Wark-Martyn, had organized. The tone of the conversation had gone towards blaming the parents. It started off kind of innocuously and all of a sudden, boom, everybody was saying the parents should be charged along with the kids and this sort of thing. In the audience was a youth who was currently in a custody setting, and I was so proud of him. He stood up and said: "I've learned I've got to be responsible for my behaviour. I've got a lot of anger towards my parents but I can't change them. I've got to sort my own life out and get on with it." I think that lad had learned a valuable lesson. He looked only about 14 but the maturity was there.

We cannot excuse that kind of victimization, but we need to realize its impact on youth and we need to realize the implications for some of the strategies for dealing with youth crime. I'll get to that in a moment. Our experience is that what works is respectful relationships: relationships, when you're dealing with victims of this nature, that empower youth. A focus on dominance or

compliance is really counterproductive. All it does is elicit in a teenager a desire for revenge. It's simple.

The discussion about boot camps—Manitoba is very close to my home and I've been following the boot camp proposals there—sounds kind of tempting, initially: structure, high demand for compliance. I think the thought is that if you have a high degree of external control, it'll somehow translate into self-control. As the reviews of these experiences in the States and a little bit in Alberta are occurring, that's not the result that's occurring. What you're getting are power issues and abusive authority by those in authority; a counterproductive kind of approach to what was intended in the first place. Those kinds of structures seem to lend themselves to adolescents who have a certain predisposition to react to authority in those ways.

Secondly, I want to draw to your attention another way in which I think young offenders are at risk, and that's some of our judicial principles. The Young Offenders Act, when it first was envisioned, was to balance rehabilitation along with strong sanctions, and I see our system moving more towards principles of punishment: getting your just desert. There's great support for that in some sectors of the community, and the judges, I'm sure, are influenced by that. The emphasis seems to be on protecting society in the short term: Lock 'em up. What I see as the result is that in the longer term we're not going to achieve what we want: looking at longer-term rehabilitation of youth so they don't reoffend. That really is the name of the game. That's why I'm in business; that's why the agencies across Ontario are in business: to prevent youth from reoffending.

But there is this rootedness in the principles of punishment. The results are evident in the incarceration rates for youth: the highest rate of incarcerating kids in the industrialized world in Canada. In Ontario, 30% of the kids who are found guilty when they come before the courts get time; get either secure or open custody. That was last year and happens in every region across the province. Some regions are a little bit higher than others, but it's at least 30%.

1710

If you look at the majority of youth who come before the courts, it's not for violent offences. It's for property offences, shoplifting, theft under \$100—I don't downplay those—offences related to wilful failure to comply, haven't met their probation terms and so on. These are not youth who pose a threat to the community or to the safety of other individuals, and yet we have a 30% record, when they show up, of locking them up.

The concern is that it's based on the wrong premise: that punishment will be a deterrence. Show me any teenager who thinks of the consequence in that nature as he's committing the crime. Most of these kids have very few skills in terms of cognitive development. Very little thinking goes between the impulse and the action. Jail has not proven to be a deterrent for kids who don't have the cognitive skills or kids who don't feel they have anything to lose.

The other concern we have is that custody is a very expensive proposition. On an annual basis, every time we

lock a youth up for a year, you're spending \$100,000 minimum; some places a bit more, some places a bit less.

Residential costs that the province bears, because the province provides the service for young offenders, eat up the majority of the budget. The custody costs eat it up. At that price tag, and as we anticipate changes to the Young Offenders Act that will lengthen sentences, the province's costs are going to escalate. The province has an obligation to pay those costs. Less money goes into where we feel the effort should be put. Prevention, treatment, aftercare is where we should be putting our money.

This leads me to the recommendations that I wanted to leave with you as a committee. We focus them around the Child and Family Services Act, which sees in its principles our youth as an investment. We would ask, as you deliberate with the public and in your own deliberations here within the Legislature, that you insist that sanctions alone do not work. There is a place for sanctions, but sanctions alone do not work.

Agencies of last resort, like ours, need to be resourced in terms of a rehabilitation agenda. Rehabilitation needs to get more strongly back on the agenda.

The province has the ability to make that part of the decision. The federal government defines the crimes and the parameters for how youth will be sentenced and so on, but how the treatment of youth will occur is the province's jurisdiction.

We have some thoughts in terms of family life, which we see as really essential in terms of prevention and return of youth to the community. Family violence really is a contributing factor. One of the initiatives that in our mind has contributed to reducing family violence is the crisis homes for women. We applaud that and we ask that those kinds of initiatives in communities where they are just developing—and in a number of smaller communities they are—be supported. It removes families from that context of violence; gives our youth, particularly our male youth, a sense of what is appropriate and what isn't appropriate.

The other comment I had that came to mind as you were in discussion with the previous presenter was in terms of provincial policy, the area of general welfare. There has been a change in the last year or so in terms of who is eligible to be a dependant within a family on welfare. When a youth comes into custody for what the judges call a short, sharp jab—that's up to three months to teach them a lesson—the youth is removed as a dependant from the family. That's new policy, to save dollars, I assume. The impact is, the family no longer contribute clothing to the youth. Probation has to pick it up. It's paid for anyhow. The family has no travel allowance to visit the youth: a bit of a hardship if the youth is across town or in another community. And the whole concept that the state has taken over for the youth is firmly implanted in the kid's mind and the family's mind. He's not part of that family any more.

I think there needs to be a relook in terms of there may be a point in terms of cost-efficiency when dependants need to be removed, but in most jurisdictions I gather now it happens from day one—counterproductive, in my mind.

The other area is a bit of a contentious one, and I don't know whether you've been part of it yet or not, but the whole redistribution of dollars as population changes occur. The issue I'm talking about here is supporting communities, healthy communities. I know within the Ministry of Community and Social Services right now there are proposals that are coming forward to the minister that talk about the need to redistribute the existing dollars. A point you made earlier: There are no new dollars. Let's get real about that. The federal government is looking at cutting back its transfer payments. I mean, we've got to look at this. A number of concerns have been raised about child populations growing in some areas and the difficulty in servicing those areas by those communities, which is not only in Comsoc but within Health now and Education.

The issue, and I think we need to speak clearly to this, is that there is potential here for destabilizing a number of communities if this is not done with care. There are proposals to look at formulae, based on population and other factors, but there are studies that show the impact on a number of communities across the province as dollars are funded, and for some areas it would be between 30% and 50% cuts. So what I leave with you is a request to look very carefully in any ways you can at that redistribution process, because I think it will have a great impact on a number of communities.

That's my formal presentation. If there are questions, I'd be pleased to respond.

The Chair: Thank you very much, and thank you in particular for the recommendations that you've brought before us. We'll begin our questioning with Mr Jackson.

Mr Cameron Jackson (Burlington South): Mr Thompson, thank you. You've come a great distance, and you've prepared a written brief and your oral presentation mirrored it quite effectively.

You raised a lot of subject area within the Young Offenders Act and children at risk in conflict with the law, but I wonder if you were aware that the recent Ontario budget actually shows a huge increase in the transfer payment from the federal government under the Young Offenders Act. It's in fact a 33% increase. I saw the numbers the day of the budget and I haven't revisited them, but it was something like \$60 million from last year is now \$80-some million. Do you have any insight about why we're getting such a huge transfer? And is that money going to be directed, as you had implied it may be, for longer sentencing, or is it for cost-sharing of rehab programs? That number sticks in my mind, and I don't know why it is so huge. It's the largest single increase in the budget to a transfer agency, from what I understand.

Mr Thompson: I'm sorry, I don't know the reason for the transfer.

1720

Mr Jackson: Perhaps, Mr Chair, we could ask research to pursue from the Treasurer or from the minister involved just why those dollars were transferred in such large numbers. We're pleased, but I think a committee with this mandate would be most interested in just what planning is going on with that. It's a 33% increase,

a huge increase. I like the fact that you've been able to give us recommendations, Mr Thompson, but I'm also interested in knowing about the disproportionate number of young offenders who are female and the disproportionate amount of sexual assault, incest and abuse which is associated with that cohort of children in this province, and whether we shouldn't also be talking about child victim/witness assistance programs, which only exist in two pilot projects in this province.

If you're sexually assaulted as a child in London, Ontario, for example, twice as many young people or children end up in court and twice as many get convictions of their assailants from a judge and a jury. This is not the case in almost the entire province outside of Toronto and London. I wonder if you could comment. Your reference to family violence seems to focus on domestic violence and that the children are introduced to this, yet there's this compelling statistic about young females who are becoming young offenders. I've seen statistics about the number of street prostitutes, for example, who emerge from this cohort.

Mr Thompson: The number of girls in custody is considerably less than the number of boys.

Mr Jackson: I understand that. But do you not agree that the largest single identifiable factor among young girls is this factor of abuse, whereas that is not the case with boys who have been sexually assaulted or physically abused? That's my understanding of the current statistics in this province that I receive through children's aid society statistics and others.

Mr Thompson: Yes, that's true; in terms of girls, almost 100%. But in terms of boys as well, our findings are that a number of them have been physically or sexually—

Mr Jackson: It's high, just not nearly as high as with the girls.

Mr Thompson: That's right. The victim assistance program is in a sense a preventive program, in terms of them escalating through the system, in that early on in the system someone advocates on their behalf so that justice is done. So often it just goes underground with them if there aren't programs like that. They end up on the street; it's intolerable to live at home.

Mr Jackson: In the interests of time, thank you very much, Mr Thompson.

Mr Larry O'Connor (Durham-York): I appreciate you coming and making your presentation today. The recommendations give us some focus in considering what you've presented. I appreciate a lot of the thoughts you've put into it.

Quite often, as politicians, we get approached by individuals looking for funding for one more program: "We know times are tight and we're only asking for one program to be funded." I think it's safe to say that across the country people look to the Young Offenders Act as the real problem, that our young people have gone all wrong ever since the Young Offenders Act came out and that what we need to do is lock them up for longer periods of time. I don't see that as a solution or dealing with the real problems we have before us.

But professionals quite often come to us and say, "But we want more dollars for our program." How do we then go out to the community and say, "It's time you talked to two or three other people and put together something that might be more comprehensive for the community and serve the needs of the child, perhaps the whole family, perhaps bringing the family and the child together to try to look at some of the causes of the problem"?

Your recommendations 1 and 3 almost dovetail. One says we have to recognize the need for the resources, and the last one acknowledges that there are very few new resources to be had. In fact, quite often in the Legislature our colleagues are telling us to cut, cut, cut at the same time. It's not always practical.

Mr Thompson: I think the name of the game in the next few years is integration of agencies' efforts: school systems working with custody operators, working with children's mental health centres.

There's a lot of anxiety within the field of service providers that there is going to be an emphasis on custody alone, that the rehabilitation emphasis is disappearing. I hear it in conversations with the judges in youth courts in their area. To get tough, in their minds, is the answer.

Mr O'Connor: Maybe another recommendation from you, one that's not here, would help us in the report this committee will write to present to the Legislature and to the people who are concerned about this issue in the province. How would you present it in such a way that we could go to the agencies that feel: "We know there aren't more dollars, but we're not the one you should be trying to integrate with something else. Leave us alone and go integrate someone else"? The reality of today is that there aren't the new dollars. There is a need to do some integrating, which doesn't mean a lower quality of service. It means recognizing that there aren't a lot of new dollars out there, and let's try to refocus some of those dollars and let's take a look at the whole need. Can you help us with a recommendation, or just some thoughts that we can formulate later on?

Mr Thompson: I think communities need to take some ownership for this. I don't think it's the ministry's alone. I know there are local planning groups developing under the auspices of the Ministry of Community and Social Services, but there needs to be a clear direction given to them in terms of: "Rehabilitation is a possibility. Come up with proposals. These are the frameworks in which we will consider them." There has to be ownership by the communities, but the communities need some direction in terms of a willingness to proceed with rehabilitation.

Mrs O'Neill: I'd like to ask you one question, and you already have begun the answer. You said you feel that the new changes—I presume regulatory changes are the ones you're referring to—are counterproductive. Could you say a little more about the way things have changed and why you feel they're counterproductive?

Mr Thompson: Was that my reference to general welfare?

Mrs O'Neill: It was your reference to the role of

parents, I think, that now the relationship is different between the parent and the child in custody.

Mr Thompson: My concern is with how the provisions of the Family Benefits Act are administered. In a number of jurisdictions, youth who come into custody through that order are removed as dependants from the parent, even if it is for a fairly short period of custody. The impact of that, in the whole treatment program and the philosophy of involving parents, is that some parents are not able to provide clothing, are not able to visit their youth, because they don't have the wherewithal to do that. And there are no interim provisions, even if a youth is out of the home, of perhaps a 30% assessment or something like that. It's very black and white. A number of parents are having to make choices between their youth, their son who is in custody, and their three other kids. They're saying: "We've got these three other kids. We have to dismiss this youth."

Mrs O'Neill: What were you saying about 30%?

Mr Thompson: That could be an option if they don't have the full costs of room and board for their youth, that there might be provisions for a youth who comes into custody for a lesser amount as a dependant. But at this point it is not that kind of administration of the policy.

Mrs O'Neill: Thank you for bringing that to our attention.

The Chair: I want to thank you very much for coming down. Somebody mentioned that you probably have come from the farthest away, from Thunder Bay. We always appreciate that.

Mr Thompson: It's still in Ontario.

The Chair: Before calling our last presenters today, I'd just note for members of the committee who may be wondering what happened to the Ontario Association of Children's Mental Health Centres that we are trying to determine that, but we'll work out another time with them. Clearly there has been some miscommunication.

1730

PROVINCIAL COUNCIL OF CHILDREN'S SERVICES CO-ORDINATING AND ADVISORY GROUPS

The Chair: Our next presenters are from the Provincial Council of Children's Services Co-ordinating and Advisory Groups: Mr Michael Cushing, who is the executive director of the Niagara Children's Services Committee, and Mr John Sheehan, the executive director of the Peterborough Children's Services Group.

Gentlemen, welcome to the committee. We appreciate your both being able to be here today. While this is the last submission of the day, I can assure you that we are as interested in your observations on this very complex issue as we were when we began several hours ago.

Mr Michael Cushing: Thank you, Mr Chairman. As you've seen from the two handouts, it's a presentation in two parts. I am here on behalf of the provincial council rather than any individual local children's planning group. My colleague Mr Sheehan will be speaking after me, bringing some of the more general points I'm making to a local level and speaking from his experience with the children's services planning group in Peterborough.

It's not my intention, given your time frame, to take

you through all the paper you've just received. In particular, there's an attachment on the end that is entitled Presentation to the Ministry of Community and Social Services, dated 1992. I believe that will afford more detail on the local children's services planning groups for members who want to follow up from today's presentation. As indicated, my points are fairly general.

By way of introduction, the Provincial Council of Children's Services Groups is the umbrella organization of roughly two dozen community planning bodies that have received recognition as advisers to the Ministry of Community and Social Services under the Child and Family Services Act. The number's a little slippery. Some of the groups are unfunded and some are not able to prevail for the long haul. In other words, some of them unfortunately have come and gone. That number of two dozen is conservative, and I'm confident in it.

The provincial council itself, as an umbrella organization, is unfunded. It works to assist the member groups with matters of common purpose, common concern. We do that through the combined efforts of people volunteering to serve at a provincial level, and we also do that in partnership with the Ontario Social Development Council.

The local groups are as diverse as the communities they represent. Within common purposes of improving the range of services and supports available to kids and families in their communities, the respective groups engage in planning, coordination, community development and community problem-solving as local conditions require. Prior to the establishment of the Child and Family Services Act, this initiative began with Ontario's children's services committees in 1978-79. From the glances I've had at Hansard, you've heard a bit about the history of this initiative in your earlier hearings.

Over subsequent years, the number of groups has multiplied considerably and the work has grown to embrace broader purposes, in some cases, than solely the concerns of children and families. While some of the groups struggle along with virtually no financial support, others have achieved greater levels of funding, often from a number of sources, including other levels of government. Unlike more standardized provincial initiatives, such as the district health councils, the names of the coordinating and advisory groups vary by community. Mr Chairman, I know in your community it's known as the community services council. There are many variations on the theme across the province, all of them representative of the same initiative, though, and with the same reference point to the Child and Family Services Act. As indicated earlier, there's further background information on the groups appended to this submission.

I have some observations in respect to the terms of reference this standing committee has set for itself.

There hasn't really been adequate time to formalize the consensus of all the provincial groups around this commentary, so I have to take responsibility for any failings or inaccuracies. I know, though, that all the groups would want to celebrate your interest in prevention. We recognize that legislators, like everyone else concerned for the wellbeing of kids and their families, are vulnerable to the necessity of attending to acute and chronic

issues of service shortages and service shortcomings. To get out in front of those demands to examine the challenge of ensuring the health and wellbeing of our children is a daunting and a critical challenge.

In our respective communities, local groups know the potential for prevention to rest in systems more far-reaching than those such as child welfare, child and family intervention and child development, the systems that operate under the aegis of the Child and Family Services Act. Broader systems, such as health education, child care and social assistance, also possess greater resource capability than the CFSA program areas. The potential for significant accomplishment in the area of prevention lies in the greater coordination of these broader systems at the community level. Notwithstanding MCSS's identification as the lead ministry for children, we urge you to maintain a broader focus.

The Ministry of Community and Social Services' emerging policy framework on children's services shows real evidence of providing an excellent template for improved coordination and increased cost-effectiveness among the Child and Family Services Act programs. Children's services groups have had the opportunity to participate in the policy development process. It's been a very inclusive process, drawing in varied perspectives and varied interests, and the apparent policy directions of the Ministry of Community and Social Services in relation to local planning have been well received by local planning groups.

Perhaps inevitably, though, that ministry's been reluctant to frame policy that goes beyond the embrace of its own program areas. The experience of local groups, however, has taught us that local planning efforts must go beyond a Child and Family Services Act focus and must incorporate the serious participation of service providers relating to other ministries and funding sources, as well as service consumers and local citizens. To be successful, particularly in relation to prevention, the children's services local planning initiative must have broad inter-ministerial support and interministerial understanding.

As the standing committee addresses the concept of at-risk children and families, our experience would suggest that in the current climate of social change and economic restructuring, many Ontario children and families are, to varying degrees, in peril. As food bank operators have reminded us, even traditional two-parent, middle-class families are one divorce or one job loss away from destabilization and the risk of unsatisfactory outcomes for their children. The recent report *Yours, Mine and Ours*, from the Premier's Council on Health, Wellbeing and Social Justice, provides an invaluable analysis of risk and the need for broad population-based approaches to the support of Ontario's children and families.

1740

Arguably, the service systems for children and families across the province are both inequitably funded, if one compares communities, and inadequately funded in at least certain service streams. We recognize, particularly in the present context of constraint on public resources, that this conclusion is disturbing—disturbing perhaps

particularly in that it is so hard to grapple with and to take action on. In our experience, however, it's doubtful that even heroic accomplishments in integration and reform of CFSA services will ensure that certain service streams can adequately address local need. Accomplishment in the area of prevention is thus that much more imperative.

There's much to be done and presenters before committee will, I'm sure, be urging your consideration of a number of recommendations. Presumably, you can extrapolate from my concerns to this point some of the concerns of local planning groups. Overall, however, we would encourage your awareness of the necessity, and we believe it's an absolute necessity, of local planning infrastructure if Ontario communities are to develop the supports and services our children and youth require.

That infrastructure, through the wide range of local planning bodies province-wide, is to a great extent in place now. For many years those bodies were in effect orphaned in provincial policy and mostly lacking—not without exception, but generally inadequately resourced, so they were mostly lacking—in the funding they required. We would suggest that investment and policy support from several ministries, rather than solely MCSS, be considered. With adequate resources, more can be accomplished, and such accomplishment is ever more crucial.

On a final note, one wonders if Ontario policy and programs relating to the development of kids and youth wouldn't draw increased and more consistent support if the goal of raising healthy and capable children were recognized as an economic as well as a social imperative. The false dichotomy of social policy and economic policy gets in the way of clear thinking. To quote from a recent article by Drs Dan Keating and Fraser Mustard:

"The most critical challenge in this period of diminished resources will be to maintain a good social environment for children at risk.... Failure to invest in families with children has potential costs to society in the form of less healthy and more poor functioning adults. Adequate support, in contrast, not only reduces those burdens but also sharply improves the prospects for future economic growth."

I am going to turn to my colleague Mr Sheehan. For my part, on behalf of the provincial council, thank you for your interest and attention.

Mr John Sheehan: Thank you very much. My name is John Sheehan. I'm the executive director of the Peterborough Children's Services Group, which is a children's services advisory group originally founded in 1979, so it was one of the original planned children's services advisory groups when that plan involved divestment of funding and a number of other responsibilities. It was restructured in 1987 to serve one county rather than three, and we presently serve Peterborough county. We're driven by a board of community members, including parents and consumers as well as service providers.

I thought you might be interested, because I think you're struggling with very much the problem we struggle with on a local level of setting priorities, if we

shared some of our experience in the last few years with that exercise. We've been at the centre of that in a community that's well known for its cooperation and caring, particularly in terms of collaborative work.

I'm pleased to say in terms of our group that service providers have really been at the leadership of making change: this shift in our board, for example, from being primarily a group of senior administrators to agencies, which many of these were 10 years ago, to there being at present a plan for two thirds of our members to be community members and only one third providers. We're almost at that point at this time.

I think what we've gone through in our community, and I've outlined it in here, is to say there are many ways of looking at children at risk. Obviously, it's not difficult to run through the figures. They're devastating. Our poverty rates have increased tremendously. The number of families that we have on social assistance is extremely high. Our unemployment rate is 14%; 14% of our families live in poverty, and it's probably higher than that. The welfare rolls are as stated. I think the nature of the type of family in Peterborough is changing, as it is in every community in Canada, and we have families that are more subject to the stresses of the 1990s in economic terms, particularly single-parent situations.

In terms of children at risk, in 1990, as an organization, we did an extensive study of our community, applying the risk factors that Dr Dan Offord developed with the Ontario Child Health Study and estimated the number of children in Peterborough county with key risk characteristics. You'll see the conclusions on page 5.

What that shows is the estimated number of children in Peterborough county that might be considered at risk; that is, they are in particular situations that are associated with, using a broad population base approach to looking at children at risk, significant mental health problems. Those are, as are well known from the Ontario Child Health Study, being on social assistance, being in subsidized housing, having a low income, female single parent if the parent is also poor—without the poverty situation, it's very similar to the situation of most other people—family dysfunction, which is the highest group. Then those children who happen to have chronic medical illnesses, developmental handicaps and other functional limitations, mobility and whatever, are at high risk for mental health problems.

I used mental health as the basis because that was the basis in the Ontario Child Health Study and also there's a great deal of overlap between those children who are at risk for mental health problems and those children who need other services. We're very much aware that the children run across all our services and the same child may be in many. It's not uncommon to have 10 contacts or 10 different agency workers or whatever in some situations, or contacts of some kind.

I think it's very easy when you get into these figures to become, frankly, quite depressed and despairing as to our ability to cope, particularly as our resources have diminished over the last little while. As they've diminished and demands have gone up, our agencies have been experiencing tremendous upheavals.

I put in a few agency statistics just to indicate this; for example, between 1987 and 1991 referrals to the children's aid society for brief service went up 250%. By 1992 and again in 1993, this figure went up another some 40%. Since the beginning of 1990, the CAS has identified an average in our community, and this is for Peterborough county alone, of 12 cases of child abuse a month. A case here is defined as any situation which is significant enough, in their judgement, to report to the child abuse registry. It doesn't mean that they are necessarily accepted by the registry, but important enough and significant enough to report.

A quick check of some of our children's mental health programs indicates referral increases in the range of 90% for some programs between 1991-92 and the end of 1993-94, and there are 30 to 40 children on the two programs I checked with on the waiting list for waiting periods of up to three months. In fact, that was the norm in one of the programs. All report a significant increase in the type of severity of the situations presenting to them over the last few years.

What's happened in our community resources during this time? Obviously, and I think we're all aware of this, the resources to the communities are diminishing not increasing during this time of demand, although there are exceptions in the child welfare, where there are mandatory services.

1750

Even in that situation, for example, just outlining some current situations, our local children's aid society has been unable to convince the Ministry of Community and Social Services to offset its outstanding deficit of \$49,000, which is a current deficit this year, and it has just announced the layoff of 16 to 17 full-time positions, or 20% of its staff. They may yet have to find another \$250,000, given whether that 2% economic constraint program goes through or doesn't. One of the staff who was laid off who was particularly important to us, I think, was someone who facilitates treatment for children who have been abused elsewhere in the community.

Most children's services agencies have lost funding. Our agency lost funding for our child abuse forum, for example, which really was staffed to 50 volunteers, prominent volunteers in the community who've worked for 14 years to promote the better identification, improvement in treatment networks and improvement of reporting protocols between school boards and the CAS and the police.

All these things have been generated by this volunteer group, which had in the last few years funding of approximately \$40,000 a year. We lost that funding. It was funded with fiscal dollars, and in the last few years it was the money that someone at the ministry could pull, that the area office could pull from a variety of programs and keep us going. When things tightened down, those funds disappeared and the program went with it.

In terms of the other sectors, the city has just cut its director of recreation and probably is moving into a more consultative role vis-à-vis recreation services. The Peterborough County Board of Education is one of the boards identified in the province for \$2.5 million less in provincial grants, and that combined with the reduced tuition

income will mean a shortfall this year of \$4 million.

On that list, let me tell you, are very clearly the social work services department, the behavioural services department, the enhancements, all those services that support those at high risk in our schools and make a tremendous difference.

I heard one of our agency people in a meeting the other day say, "You know, the cases I'm most successful with are the cases referred by the social workers from the school board," because they know why they're coming, they're well prepared, they have entry back into the system when they go out. It works.

Losing those connections—but the trustees don't always understand that, even if the staff do. It's a very difficult situation for them to face, and they're not at the top of the list. But I think it was a difference between them disappearing if we only raised taxes locally by 2% versus 4%.

What can we do and what are we doing? Locally we made up our minds some time ago, folks, about two, three years ago, with the Children First document. That was really a seminal document for our organization and for many, I think, of the children's services planning group. We've been attached to that theme ever since. We'll never have enough money to serve high-risk children and children with mental health problems in the way we want to, using the systems we have.

The systems we have are outdated, mismatched styles of service, all those kinds of concepts that I'm sure you've heard about. We'll not have enough money and we know it. We also know we're not doing the right things at the right times and that we need to integrate, not just across our own children's services but across health, education and recreation. If we can't put that together, we can't do our job.

From that point is where we move to changing our board structure entirely, moving very much from yes, let's concentrate on maintaining the dollars we have for those children at risk, let's make sure they're used properly and with priority, but let's make sure we're working with the communities to identify what they need to raise healthy children. We cannot start with children at risk.

We very much moved into a partnership with parents, a partnership with education departments and whatever. We have signed agreements between all the children's services agencies, the boards of education, the recreation department in the municipality to move on integration. We had a proposal in to the ministry three years ago for some funding to help us move that cross-ministry; it disappeared.

So we've been operating. We just go with it. We've been trying to do and have been doing some very exciting and very innovative work, and we're very pleased with our results.

What has been really exciting, I think, is to work with parents and with our neighbourhoods in terms of saying to them: "What do you need? What do you want?" They give us very different answers than the professionals do in the agencies. I think the professionals have come around a great deal. We have agencies like Kinark Child

and Family Services in our community, for example, which has redirected residential resources and, combined with some resources from the children's aid, has created a program called Families First.

Families First does what the families want them to do. They essentially direct their service. They say, "This is what we need to keep this child out of residential care." That's it; we do it. The agency does it. We've changed our thinking to be very much in tune with what used to be the Children First document. It's now being echoed, I think, in Yours, Mine and Ours. I don't know what the order of that is.

I think we're now doing some very creative work in a couple of neighbourhoods, a rural one and an urban one, with the help of the Laidlaw and the Lawson foundations, which are helping us do some experimental work in there, to say: "You tell us how you want services delivered. We're going to change the whole system in Peterborough county to match what's happening there." We have the service providers with us on that. They're on our committees, they're working with us. We have our neighbourhoods there.

In our suggestions and our recommendations I'll try to be as brief as possible. We know the big fix. I don't think the big fix is going to work for our community as it is for any other community. I think you were on the right track and you've had before you all the things we needed and we continue to need: child care reform, reasonable and stable income for families, the children's allowance proposal, decent housing, a commitment to removing barriers to cross-sector integration. What happened to the secretariat for children and youth? Where did it go? These were all the supports we need to move forward.

We're saying that what we think it takes is the same thing it took for us: Jump in, make a commitment and do some bits and pieces, if nothing else. Do it incrementally. It just has to move forward one step at a time, slowly and in intimate sync with different communities. Different communities are going to define their needs somewhat differently, just as families do, but I think just that moving forward incrementally. I'll stop there.

The Chair: Thank you both very much. There's a lot of food for thought, a lot of ideas there. We're not going to have the time to pursue them all as much as we'd like, but we do have a few minutes for questions.

Ms Carter: I'll concentrate on John's part of it, since that's where I come from. I think we all share this concern that children are vital and should have priority and their needs must be attended to. I think we agree that the broad prevention, rather than waiting for children to get into trouble, is obviously the main tactic.

I think this government is doing that in the sense that we're putting a lot of money into social housing. We've increased day care spaces. We're trying to get people back into jobs, although that, of course, is the intractable problem, as everybody knows.

I also agree with you very much that Peterborough is known for cooperation and caring. I'm for ever coming across proof of that in the different agencies that I have

dealings with. I see the number of volunteers involved and, as I say, the caring that is there.

There are just a couple of points I wanted to comment on. You mentioned the children's aid society, and I know there are real problems there. I don't think it's just funding. I think there are problems between management and the union and I understand there is going to be some kind of onsite review to find out just what the problems are there.

1800

Also, you mentioned that the board of education is getting \$2.5 million less. I just want to point out that's not a cut; that's the operation of a system which has been in place, I understand, for quite some time where the property tax base of the whole province is reviewed—I think it's every five years—and the share of the pie that each area gets varies automatically as a result of the findings on that basis. This wasn't something that should have altogether taken the school board by surprise.

I guess the corollary there is that the areas that don't come out of that too well are the ones that, theoretically at least, have a little bit more in their tax base than another area might have. I understand this time it was the Toronto area that went down. They had to take a little bit more of the pie.

Those are just a few comments, but certainly I think you people are doing a good job and I agree with you that the Ontario child income program is something we would like to see in place. I understand it has been deferred through lack of funds, but I think everybody in the government would like to see that as soon as possible, and some of the other things that you suggest.

Mr Ron Eddy (Brant-Haldimand): Back to the subject of the children's services advisory groups, I appreciate your presentations and hearing about the work of the children's services committees in the various communities. I well remember when they were started by the previous government. There were nine pilot projects, or something like that, established. That doesn't matter; that's history.

You have the children's services committees operating in some communities and I know there are social planning councils operating in some communities. What I really want to know is, how do they work together and what should be the relationship?

You said that the provincial secretariat is gone, so it looks like you have to work locally in order to accomplish, and you are in many ways. What's the relationship between you, the committees, and the local children's aid societies and what should be the relationship? Do you see the area health councils as being a model for community planning councils and children's services committees? What do you see as the proper way of handling this? I appreciate the job you're doing and I think it's needed and I think some of the communities that don't have such committees should have them operating.

Mr Sheehan: I'll answer first and then I'll leave some time. I can tell you what's happening in Peterborough. We have a district health council and we have a social planning council.

Mr Jackson: And a children's aid society.

Mr Eddy: Yes, of course all communities have CASs.

Mr Sheehan: I used to be president of the social planning council, so I know that scene very well.

We have a planning alliance. We have an agreement, an alliance between our planning bodies that works quite well. We meet monthly, we share agendas, we make sure we're not overlapping in different areas. We sit on each other's committees when there is overlap. We work fairly closely together in our local community in terms of the planning.

We have also met provincially—and I'll let Michael take off on this—the district health councils, social planning councils and the children's services group, on our own initiative, to sort out this relationship. I think you probably are aware that the tension that precipitated this was the move to have the district health councils move into the social planning area with the long-term care reform, which none of us were very pleased about, actually.

Mr Jackson: You're no further enlightened about either, as a matter of fact.

Mr Sheehan: We're concerned. For example, locally we're concerned because children are part of that long-term care reform and we can't even be at the table. The way it was laid out, it has to be individuals who are members. We're not even in the program as planning partners to put those advisory committees together.

Mr Cushing: I'm probably only going to be embellishing what John had to say. Particularly in communities where resources devoted to local planning are scant to begin with, the last thing any of us engaged in the process can afford to be is proprietary or exclusive about mandate.

As John says, there's activity under way now to try and sort out respective roles and functions with social planning councils which emerged usually or in most cases across Ontario at a different time without any root in government, as the children's groups tended to have in the Ministry of Community and Social Services, and very often found themselves pursuing issues of social planning and advocacy on broader issues, many of them federal, constitutionally.

But social planning councils, like the children's services groups, vary across the province. The common denominator is that in any of our communities where both exist, the only sane way to operate is together and to work it out together.

Then, as John says, the district health council model is a different model. It's of course Ministry of Health driven and the appointments to the district health councils are Ministry of Health appointments, so that in terms of the jargon of planning that we tend to use, we don't see those as community planning bodies in so far as their appointments aren't from the community, which isn't to disparage their work. In fact, in all of our communities, we're trying very hard to work as closely as we can with the health councils. Sometimes we find that the marching orders they operate under do cut us out when we believe there's a role, particularly with regard to developmentally

handicapped kids and other kinds of chronic conditions that are included in long-term care.

But the long and short in my answer is, some Ontario communities have the benefit of a health council, a children's services group and at least one social planning council. I think in virtually all of those communities we're trying to figure out how to put our actions together for greater effect.

Mr Jackson: My question was going to be quite similar to Mr Eddy's, so I'll make it a supplementary.

I'm not really hearing from you anything new or unusual or particularly guiding of this committee. I mean, consultation's a wonderful thing and coordination's even better, but issues around primacy are critical issues. We had a brief exposure to it in Children First in terms of looking at which ministries have responsibilities and what new entities should be formed if the government's going to resolve it.

Long-term care is the example, it's almost a horrific example, where we had too many ministries involved. We've scaled it down and yet its implications out in the communities for the decision-making entity which will consult and coordinate—it's quite frankly a mess and it's way behind schedule and mired in controversy. We shouldn't proceed to do that in children's services if we're going to do exactly what we just did in long-term care.

I'm frustrated. I want to hear from people. I have my own ideas, but that's what governments have been doing for the last eight years: tell you how we would change it. I really haven't heard from anybody what models we should be working on. You have said that each community's different. I buy that. But I'm trying to hear from people like yourselves, front-line workers who are doing assessments, who are looking at the numbers, who are looking at the retrenched services, the cuts, saying to any government, "This ministry should get the hell out of this business; this ministry over here should take more responsibility."

School boards should not be able to, at a whim, get in and out of services for high-risk children; hospitals shouldn't dump it because of—and all these are backed up by ministries' indecision.

Forgive me if I sound harsh in this.

Mr Sheehan: I'm delighted to answer.

Mr Jackson: For nine years I've heard the same argument. I'd like someone to tell me which ministry programs should we be getting out of or transferring across. We did it with long-term care. Not everybody's happy. But I'd like to hear how we do it in children's services and what you think. If you were the deputy minister today and you were whispering in the minister's ear, what would you tell them to do?

Mr O'Connor: What a speech.

Mr Jackson: It's not a speech. Just a minute, Mr O'Connor; it's not a speech.

Interjection.

Mr Jackson: No, you interjected, Mr O'Connor. It's not a speech. That was a legitimate question.

The Chair: Order.

Mr Jackson: I'm frustrated because I agree with everything they said.

Interjection.

Mr Jackson: When will you stop interrupting, Mr O'Connor? You haven't even been here for most of these meetings.

1810

The Chair: Order, please.

It is the end of the day, but any reflections you have on that question and issue would be helpful.

Mr Sheehan: I think the task is an extremely difficult one and it's one I actually, in reviewing one of our reports, saw that we addressed at one point, and that is how do you translate needs into services and how do you prioritize? I think it's an extremely difficult one because in actual fact it's not a direct line. There are cultural, there are political, there are economic realities in each community that determine how that gets translated. I think in long-term care reform, if you take that as a process, originally it was the community that was going to decide what that multiservice agency looked like, or whether it had a multiservice agency, or how it did its service. That was the original plan. I worked for a hospital at that point so I was very aware of that. I think what happened was, then that got translated into some one-solution kind of thing that the community won't buy.

If you ask the parents, and we did recently, how they saw the reformation of children's services—and these are people who are using them and may have two or three children—they would say, "We don't want a super-agency. For God's sake, don't give us a superagency. What we want is a little more information, a little better access," this kind of thing. That's what I'm talking about as incremental. We as planning organizations are gearing the needs and the services as we go in real concert with the community. I'm sorry; that's tough, it's indirect and it's small, but it works, and that's what's happening in our community and it's working in our community and I'm really excited about it.

Despite all this misery that we're dealing with and all those cuts, those agencies are excited; those parents are excited. There's a tremendous energy, at this point, from taking that, "Oh my God, how are we going to do this?" to saying: "How do we prevent some of this happening? How do we look at all the assets in our community?" What we need, in terms of the ministry, is to get it out of the way in terms of some of this interministry stuff, get their act together and start talking to each other.

When child and family services doesn't know what's going on in child care because it's happening in the cabinet and we can't find out from the policy people, when we're meeting around policy, what's going on because they don't know, they don't talk to each other, that's bizarre, because on the community level, if we don't have good child care, we have a lot of problems downstream. So you've got to get it together. I don't know the answers at this level. You know the answers at this level.

Mr Cushing: I realize that my presentation was

somewhat oblique and so I had in my back pocket a list of blunter things. I'm trying to decide how many of those to give in a whole bunch.

Mr Jackson: This is your moment, and you're on TV.

Mr Cushing: The first of them: I read in the Hansard you heard from Ms Telford from Ontario's Institute for the Prevention of Child Abuse. If I read correctly, she urged you not to be overly distracted by the Big Bang theory, the kids' authority concept. We'll preoccupy ourselves with issues of devolution of authority, with issues of adequate accountability for fiscal authority.

I was the director of one of the initial pilot children's services committees. At a certain point they foundered, if for no other reason, on the fact that it meant major legislative change to turn things over to the municipalities. If we do that to ourselves again I fear we'll founder again. There are a lot of good ideas short of that kind of Big Bang approach. So my first comment is, please don't get too distracted with the vehicle of change.

The second comment is one I've already made: The action is well beyond the Ministry of Community and Social Services, as important as it is. Somehow, Ontario and its respective ministries collectively have to assert the priority of kids. Rather than identify a lead ministry, let's identify a government.

A third comment is the report card concept which is in Yours, Mine and Ours, an Ontario report card and a local report card. We feel that groups like ours are potential vehicles for local report cards. There are other groups like social planning councils that contribute as well, but there's something very specific in the calling to account that lies potentially in the report card concept. For us as a province, for individual communities, there's something quite exciting there. It holds a mirror up to us that tells us what we mostly know, but we read it in passing government reports. What we mostly know is that we're not doing as well as we should be. We know it from the dropout rates, we know it from the young offenders custody rates, we know it all over the place, and yet somehow we duck it. The big report card concept does seem to have something that I think is quite valuable.

I think around this table we probably have members of the Legislature who have cut through some of the jargon and mystification that goes with kids' services. But I think all members have to avoid being distracted by program specifics and by the sense that there may be CAS kids and young offenders and developmentally handicapped kids and that somehow these are exclusive categories. In fact, these are our kids, and they can turn up in one or another or many of these systems at any given time. Again, the need for action on all fronts.

To use a specific case in point, a situation I'm sure many of you would be familiar with as parents: A child whose learning needs go unattended to, particularly if there's a specific learning disability of some kind, in all likelihood will turn up in the special ed system of the school board. If the service received does not meet with

success, the child's frustrations and the child's anxiety in all likelihood will emerge as an emotional or a behavioural problem. That child will, in many communities, then be in the children's mental health system.

As an adolescent, or a post-12-year-old, that child acting out continuing frustrations becomes nailed as a young offender. There are Ontario Family Court judges—and one that I copresented with a number of years back, Judge Steinberg in Hamilton, suggested that a preponderance of the cases coming before his court are frustrated kids with learning disabilities.

I can carry on the notion. We know that the families under stress from those kids may split apart. They may turn to a CAS for voluntary help, or they may split apart and inadvertently neglect their child. Their frustrations in turn—we all saw the television show *The Trouble With Evan*, I assume. These are systems; people get angry with one another. CASs end up involved in these situations as well. The same child can turn up in any or all of these systems, very often simultaneously.

We do know a great deal of what needs to be done. Having encouraged you to not preoccupy yourselves with the big authority concept in *Children First*, please look seriously at the service model in *Children First*. The most normalized settings, the pre-paid, pre-capitalized settings, community-by-community across this province to deliver kids' services are schools, and I would add doctors' offices to that too.

Dr Offord, who if you haven't heard from I assume you will, in his research shows that our specialized kids' mental health systems very often don't deal with most of the kids' mental health problems. In fact, those kids are dealt with and usually not as adequately as anyone would like, but they're seen by teachers and they're seen by family doctors. If that's where the kids are being seen, let's organize our service systems around those people and their capacity to assist.

We know a great deal of what needs to be done. To the extent that we don't know all of what needs to be done, the Ministry of Community and Social Services innovation fund, announced by Mr Silipo on May 10 or 12, I think, was taken as a very good sign by communities across the province. There's a concern that the dollars are scarce, the dollars are limited, the dollars may only be one year, but we do need to prime the pump if we're going to get more innovation, because we don't know all of what needs to be done.

The Chair: Thank you very much. Again, we're not only out of time, we're over time, but we do appreciate very much the fact that you've set out a number of interesting avenues for the committee to follow.

Mr Cushing: Thank you very much.

The Chair: The committee will then stand adjourned until 3:30 tomorrow. If I could just say to committee members, we have a pretty loaded schedule tomorrow and we should get started at 3:30 if at all possible.

The committee adjourned at 1819.

CONTENTS

Monday 30 May 1994

Children at risk	S-1521
Ontario Association of Children's and Youth Institutions	S-1521
Nancy Peters, executive director, Massey Centre for Women	
Maria Bertoni, executive director, The Boys' Home	
Ontario Teachers' Federation	S-1526
Douglas Loughheed, principal, Danforth Collegiate and Technical Institute	
Margaret Ann Loughheed, guidance counsellor, Northern Secondary School	
Ontario Contract Custody Observation and Detention Homes Association	S-1531
Robert Thompson, president	
Provincial Council of Children's Services Co-ordinating and Advisory Groups	S-1535
Michael Cushing, acting chair	
John Sheehan, executive director, Peterborough Children's Services Group	

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- ***Chair / Président:** Beer, Charles (York-Mackenzie L)
- ***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- *Carter, Jenny (Peterborough ND)
- *Cunningham, Dianne (London North/-Nord PC)
- *Hope, Randy R. (Chatham-Kent ND)
- *Martin, Tony (Sault Ste Marie ND)
- McGuinty, Dalton (Ottawa South/-Sud L)
- *O'Connor, Larry (Durham-York ND)
- *O'Neill, Yvonne (Ottawa-Rideau L)
- Owens, Stephen (Scarborough Centre ND)
- *Rizzo, Tony (Oakwood ND)
- Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Also taking part / Autres participants et participantes:

Jackson, Cameron (Burlington South/-Sud PC)

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Boucher, Joanne, research officer, Legislative Research Service

CA20N
X012
-577



S-54

S-54

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Tuesday 31 May 1994

Journal des débats (Hansard)

Mardi 31 mai 1994

Standing committee on
social development

Comité permanent des
affaires sociales

Children at risk

Enfants en situation de risque



Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944 – 1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Tuesday 31 May 1994

Mardi 31 mai 1994

The committee met at 1533 in room 151.

CHILDREN AT RISK

Consideration of a matter designated pursuant to standing order 125 relating to children "at risk."

The Chair (Mr Charles Beer): Good afternoon, ladies and gentlemen. We are meeting again pursuant to standing order 125 regarding a designated matter, children at risk.

ONTARIO ASSOCIATION OF
CHILDREN'S AID SOCIETIES

The Chair: Today we have three groups of witnesses. I invite first of all the children's aid societies, those who will be attending with that deputation. I might ask Mary McConville, the executive director of the Ontario Association of Children's Aid Societies, to introduce her colleagues.

We thank you very much for agreeing to come together. We have done this with several groups. As you may appreciate, we have 12 hours under standing order 125, which makes grouping a little more critical, and later this afternoon we have three children's hospitals appearing together as well.

Welcome to the committee. Mary, we're in your hands. We will have a full hour. You lead us where you will.

Ms Mary McConville: The Ontario Association of Children's Aid Societies welcomes the opportunity to appear before you today. I'm the director of the Ontario Association of Children's Aid Societies. I'd like to introduce my colleagues, who will follow me with some remarks.

With me are Bill Charron, executive director of the Niagara Family and Children's Services; Mr Roy Walsh, executive director of the Brant Children's Aid Society; Mr Jerry Muldoon, executive director of the Renfrew Family and Children's Services; and Mr Bruce Rivers, executive director of the Children's Aid Society of Metropolitan Toronto.

Just to make it easy for you, if you'd like to follow along with what we're doing here, on the right side of your package is each of the presentations that are being made today. On the left side is reference material you might want to use at some other point in time.

We would like to begin by congratulating the committee on its timely decision to consider the subject of children at risk. Our social climate is changing rapidly, as reflected in the dramatic changes in family structure and lifestyle. The economic climate can only be viewed as more hostile towards young families raising children.

We face two enormous challenges with respect to our future. The first is the need to support the healthy development of all children through effective public policy, a "first call" on society's resources and a shared responsibility for their welfare. Secondly, we must ensure that children with special needs and those at risk receive effective and timely intervention to support their individual needs and to reduce the risk of maltreatment. All these children must have equal access to support services that encourage healthy adjustment to their communities.

The committee has had the opportunity to hear from many others about broad strategies to support the healthy development of children. We wish to speak to you today about the particular role of child welfare in our local communities.

The mandate of children's aid societies is expressed in section 15 of the CFSA. A full description of the mandate is in your package, but to summarize, the function of a children's aid society is to investigate allegations of child maltreatment; to protect, where necessary, children who are under 16 years; to provide guidance, counselling and other services to families to protect children; to provide services for the prevention of circumstances requiring the protection of children; to provide care for children admitted to care under the CFSA; and to provide adoption services.

Child welfare is not simply about investigation of allegations of child abuse and neglect and taking children into care. It is about the early identification of risk and the amelioration, to the greatest extent possible, of the conditions which lead to child maltreatment. It is also about galvanizing communities and a whole range of other support services to strengthen troubled families and to assist in the protection of children where required. We passionately believe that child welfare's prevention role must be supported and funded accordingly.

Children's aid societies have been in existence in Ontario for more than 100 years. Over the past century, we have developed an expertise in dealing with abused, neglected and abandoned children. At the same time, we have learned about the causes of maltreatment of children and have developed an understanding of prevention strategies to assist families in crisis.

Some of the social conditions frequently found in families on protection case loads are poverty, social isolation, inadequate housing and high-risk neighbourhoods, a family history of abuse and addiction to alcohol and drugs, to name a few. It is the compounded effect of such conditions that creates the highest risk for children.

We have also learned a great deal about the nature of services that support an early identification of problems that reduce unnecessary admissions to care and shorten lengths of stay for temporary placements. We have learned about the needs of children in care, the traumatic effects of separation and the necessity to provide support for the developmental needs of these children through the significant transitional periods of their lives. We have, last but not least, learned that the parenting role does not cease on a child's 18th birthday.

For some 4,500 children who are crown wards of the province, we have a special responsibility that should be viewed in the context of this complex and changing society. These young people also require the support and care of their communities and of the state as a whole, not just the Ministry of Community and Social Services.

Child welfare services are not uniform across the province. This is the result of funding inequities and a lack of common understanding of the role of child welfare. But we have been highly successful in developing new approaches to our work, some of which my colleagues will share with you today.

Our vision of the child welfare services of the future would include a spectrum of support services to enable families; closer service links with mainstream service delivery systems through innovative programming; community-based service delivery directed at targeted high-risk populations; mandatory use of alternative dispute mechanisms; access to protection services for children up to 18 years; and a more integrated approach to delivery of specialized services.

1540

Some obstacles to effective child welfare intervention, which we won't dwell on but would like to mention, are judicial interpretation of the least-intrusive principle; lack of universal access to alternative court measures such as mediation; the unproclaimed sections of the Child and Family Services Act—for example, the section on confidentiality and records, the use of intrusive procedures and the use of psychotropic drugs; the absence of a legislative link between family violence and the harm of children; and the lack of protection and intervention for 16- to 18-year-olds. There are other obstacles, including the inadequate funding policy, which we've spoken to on other occasions.

The context within which child welfare functions is extremely important. We support the adoption of a population-based approach to the healthy development of children as proposed by the Children and Youth Project Steering Committee of the Premier's Council on Health, Well-being and Social Justice; that is, the Yours, Mine and Ours document.

Following the presentations by my colleagues who will provide you a unique window on prevention programs in child welfare intervention, I will refer to our recommendations.

Mr Bill Charron: I welcome this opportunity to share with you our thoughts concerning the important issue of protection of children and children at risk.

Niagara Family and Children's Services has a vision

that every child will be in a caring family. The program I am going to outline for you captures the spirit and intent of our vision and, in doing so, provides the community with an excellent opportunity to ameliorate the conditions that lead to the need for protection.

The program that I'm going to profile is called the day nursery parent enrichment program. It's been operating in the Niagara region since 1980. Currently, the program is being provided in six locations in the region, serving well over 300 children and families per year. It's funded by the Ministry of Community and Social Services under the Day Nurseries Act.

This program began as a community response to a concern identified by our regional health unit nurses who were concerned that a number of young, single parents were struggling to raise their children without adequate income, support or resources. It was felt, and their view was shared by our local children's services committee, which is our coordinating body, and ourselves, that these children and these families were particularly vulnerable to health, behavioural and parenting problems. They were at risk.

Our agency was asked to operate the program. You may ask, what is a children's aid society or a child welfare agency doing in the day care business? It's our belief that child welfare must work to prevent the need for future involvement and, more importantly, to prevent the need to protect children from harm and potential risk from harm, either physical or emotional. The feelings of the task force on child care were particularly relevant to our decision to move ahead. They said, "A system of child care aimed at providing quality care to all children would be the primary prevention mechanism to provide early detection and treatment."

It goes on to say, "Good child care could also provide parental training and support for families at risk while providing positive role models for their children." This is certainly something that we emphasize in our program, as you'll see.

The funding provided to child welfare agencies does not generally support preventive initiatives. Thus, we saw an opportunity, through child care funding, to demonstrate what could be accomplished.

The program that we developed is unique. It has three components. The first is that we provide affordable preschool education for children from disadvantaged families in high-risk neighbourhoods. We were able, through the help of our community partners, to isolate those neighbourhoods and indicate clearly that these were the areas that were most in need in our region.

The second is that we make the program accessible by providing transportation for children and families to and from the school setting. We have removed a major barrier that prevents families from accessing good child care.

The third and, I think, the key component is that we provide through extra staff an opportunity for parents to improve their parenting and child-rearing skills through weekly group meetings and individual support. We also emphasize enhancing motivation of parents and supporting directions needed to improve their personal lives.

There is something for the parents. Use of this, and linkage to community partners, is an essential part of this component.

The benefits to the child in this type of setting are enormous. These children now have an opportunity to take part in quality preschool education designed to ensure normal growth and development, as well as to build social skills and self-esteem. The program also identifies and addresses deficiencies with the goal of helping these children be at par with others entering school. For example, developmental delays and speech problems are assessed, community intervention planned and services provided. These normally, if they were outside of our parent enrichment program, would not be picked up, in many instances, until the child attended kindergarten or grade 1.

The Children and Youth Project Steering Committee's report *Yours, Mine and Ours* tells us that in the transition years leading up to entry into the formal school system in grade 1, it is imperative that early childhood education be available in order to "give children the healthy start they need and produce children who are socially and academically prepared when they get to grade 1." It is our experience that the chances of social success, and ultimately employment and social responsibility, are greatly improved. As well, the children benefit from improved parenting skills developed by their parents in the program and a more positive home and family situation.

The parents, through the weekly group meetings that we provide, learn life skills; they also have parent training; information is provided regarding community resources, and there is group and individual support. The result for many is improved self-confidence, better self-esteem, better parenting, enhanced coping skills, a supportive network and knowledge of available community resources that they can access, that they don't have to do through an agency. Many of these moms have found the strength to escape abusive situations and have become more effective parents and also have entered either retraining or educational programs. We've included in your package a number of comments from the moms regarding their experience in the program.

The response to the program in the Niagara community has been overwhelmingly positive and is demonstrated by the commitment of our partners. We, as a child welfare agency, manage the program and direct the program. Education provides classroom space and special service support. Public health nurses provide education, individual support and in-school health services, and there are many other partners I have not listed here, depending upon the individual school. Public health nurses, educators, family physicians, child protection, social workers and courts depend on the program as a preventive support measure.

Our agency's experience and the research we've done suggest that the program works. Assessment data demonstrate significant positive changes in the children. Admission to care from this risk group is limited and child wellbeing data suggest significant reduction of risk factors.

The research in the field of preschool programs for dis-

advantaged children suggests that programs of this nature are an excellent investment for the taxpayers, returning \$6 for every \$1 invested in a one-year program. We've provided a summary of those research findings for you.

The care and safety of Ontario's children is not only the responsibility of the children's aid society; it is the responsibility of the community. Programs such as the one described, we believe, demonstrate how a community response can work, preventing the circumstances leading to child maltreatment.

Early intervention promoting health and wellbeing of children at risk is a necessary component of child welfare. Child welfare agencies view this type of program as an investment, an investment in the future. Thank you.

1550

Mr Roy Walsh: "My experience during the three years since the formation of the society is that constant care and watchfulness is necessary in order to successfully do the work at which it aims." These are words from the founding executive director of the children's aid society in his annual report to the society in 1897. It's in this tradition of constant care and watchfulness that on behalf of the society we express our views to you today.

In support of the assumptions in the *Yours, Mine and Ours* document, our society in 1991 opened up a unique child welfare resource in the province of Ontario. Our family resource centre is staffed by early childhood educators and social workers along with the active participation of community professionals. It provides a wide variety of family support services which are designed to promote and enhance family living and to foster independence and health among the at-risk participant member families and youth.

In 1993 our annual report celebrated our community partnerships with 12 different partner agencies participating in more than 30 group programs per week, offering services to 250 families with a child membership of over 600.

Family support programs are designed to assist families to cope successfully with the obstacles in their lives that place their children at risk. The provision of this help is family support. Does it work? Yes. In cooperation with Brant, London and Waterloo children's aid societies, the centre for social welfare studies at Wilfrid Laurier University conducted a three-year outcomes research project on mutual aid organizations in child welfare.

Their findings: The participants had one half to one third less children come into care than did the comparison group. When children came into care from the participant families, their length of stay tended to be four to eight weeks shorter than the comparison group. Participants in a mutual aid group showed significantly less involvement with formal services than did the comparison group. In a number of other factors including social isolation, coping skills, self-esteem, family violence, personal health, the mutual aid participants scored significantly higher than did the comparison group after a three-year intervention.

The cost-effectiveness of this kind of intervention was as follows. If 40 families were served over a year in a mutual aid group, the result in annual savings by reduc-

ing children coming into care would range anywhere from \$16,000 to \$34,000. This would represent the saving necessary to provide a measure of professional support to the program.

Permit me now, if you wish, to borrow a few of the voices from the women who were involved:

"I'm a different person than I was six months ago, and I'm a different person than I was a year ago. I'm a lot stronger, healthier, and I can handle...problems...they are not the end of the world like it would have been a year ago."

"I'm bonding more. I told the children that...which I'm not fully bonded yet to those two...but the bonding didn't start until I actually came to the parent mutual aid organization."

"Just having someone to talk to when I need them...if I need to talk I know I can talk to someone."

"What can I do? I don't know anything. I'm dumb. I'm stupid. I have no skills, no abilities, no nothing. I just take care of my kid. I cook and I clean house. Well there's now many skills and abilities right there.... Being involved" with this group, "being on committees, doing things for the group, it's like 'Hey, we can do something.'"

"If someone is going to a lawyer for the first time and they are scared...one of the members will go with them...going to court with each other, supporting each other, providing child care support, monetary support, housing support, even providing food to each other, having someone to talk to at 2 o'clock in the morning when you can't sleep."

"And the kids have been changing a lot. They feel more responsible...they're not fighting like" they used to be, "they are not as scared, they are talking. And the parents feel more confident and secure, and they know really what they are doing with their children."

These results have been most encouraging, and building upon this evaluation from the university we've utilized this model now with the local family violence women's shelter and we've also developed this model in three high-risk neighbourhoods in the city of Brantford. This has been managed all the while the Ministry of Community and Social Services has been placing increasing pressure on the whole field to restrict ourselves to the investigation and monitoring of families of children at risk.

We've funded this program at the local level, primarily through the Day Nurseries Act and through the local area office, accepting the fact that this was a viable child welfare alternative, but funding policy tends to restrict us to our monitoring, investigating capacity.

The causes of child maltreatment spring from isolation, poverty, inadequate housing, health and education and pathology. It's only in providing a range of services that we can reasonably carry out the mandate vested with us over 100 years ago.

Additionally, I would like to focus the little time I have left to bring to your attention a number of issues that bear a legislative response. These will be spoken of specifically by Ms McConville in her recommendations.

The child-serving and health care professionals, as well as the general public, have for a number of years been well aware of the impact and the effects of family violence upon children, yet the Child and Family Services Act does not find that a child exposed to family violence is a child at risk and in need of protection. Social workers' hands are tied unless the child is physically injured or abandoned. We feel very strongly that a child who is subjected to a history of family violence is a child in need of protective services and that the CFSA should be so amended, with reference to the emotional harm provisions of section 37(2)(f).

Furthermore, I'd like to address a number of legislative changes that you may refer to at length, which are appended. We believe that 10 years after the introduction of the Child and Family Services Act we're not very much closer to defining a child's best interests than we were 20 years ago. We submit that the courts currently have no special ability to fairly determine what the best interests of a child are, because the act relates primarily to the provision of rights of procedure rather than to the right of substance as those relating to the necessities of life.

Furthermore, the civil court system is slow, it's expensive and it's emotionally painful for the parties involved. In short, an adversarial courtroom is probably the least desirable forum to determine a child's best interests. It's time to learn from other jurisdictions like Great Britain, the Netherlands and New Zealand, which utilize lay tribunals and family mediation as a more appropriate, effective and inexpensive form to address the best interests of children at risk.

Mr Jerry Muldoon: Mr Chairman, members of the committee, I work as the director of Family and Children's Services in the county of Renfrew in the city of Pembroke. I am very pleased to be here. I suppose to some extent I can represent the great northeast.

I have very few minutes and with those few minutes I would like to speak to issues and concerns with the service structure in the province, and more specifically about the concept of service integration. The reference for your attention is the burgundy one.

All of the members of the committee I'm sure are familiar with references to the social service system as fragmented, disjointed, poorly understood, turf driven and impeded by multiple barriers to good service. These negative references are in many instances accurate portrayals of a service system which is, however, highly committed, in my opinion, to children and to families and I believe capable of the kind of major transformation which some of us believe is essential for this system in the immediate and short-term future.

References to transformation of the service structure mean that systematic, accessible and effective services must be seen by users and the general public as the routine expectation. Multiple agencies, multiple systems and multiple mandates have served to divide the client into many pieces to the point where the service system is as complex as the major problems it is intended to broker and to resolve.

During the past five years in the county of Renfrew

we've managed, I believe, to successfully integrate the non-teaching services of boards of education and the child welfare functions of a children's aid society, and I use this particular model to demonstrate what I mean by service integration. By integration, we quite frankly mean more than coordination, we mean more than collaboration and more than rationalization, those words that we hear a great deal about. By integration, in this particular model and in others that I'll describe, we refer to a mixing of the mandate and function, to restructuring the existing service model and to blending in a businesslike partnership the delivery of a service. I'd like to demonstrate that.

1600

In this blended or integrated model, the mandate of a child welfare agency is combined with the mandate of an educational authority, like a board of education, and the resulting social service is delivered from full-time school-based social work staff. These staff are jointly funded by a board and by a children's aid society. They're employed by a children's aid society, but they're operationally controlled by the principal of the school.

The delivery of child- and family-based counselling services for mental health and child welfare purposes in the model I've just briefly described I think achieves a number of objectives.

(1) The costs are shared, so duplicating and competing interests and services to some degree are removed.

(2) The community, through the school, assumes many of the powers and responsibilities of child safety and child protection rather than having a children's aid society operate in isolation from the rest of the service system.

(3) The social and financial costs of apprehending children are dramatically reduced because early identification of problems and risk reduces the real rate of apprehension. Quite frankly, we've found, particularly in the high schools in which this model operates, the rate of admission to care has been reduced by about 80%. That's over the course of four years, so it's a statistically significant and I think consistent finding.

(4) The rate of school suspension is dramatically reduced because family-based contact is initiated by social workers who essentially work for the school but they have the powers of a child welfare agency or a child welfare system at their disposal.

(5) An education/child welfare partnership emerges which allows these systems to jointly use their best skills and to focus their attention on child-centred services rather than the needs of the system.

(6) Last but not least, it's a simple approach. The user quickly accesses what we would call a transparent system, gets what he or she needs and leaves the system with all of the parties, including the user, well informed rather than wondering what happened.

In the next phase of this particular model, the school support counsellors, who are social workers who are employed by the board, will gain direct access to child welfare resources and avoid the intake and assessment process, which is often duplicated and lengthy in many of our systems. We propose to entrust child welfare

resources to educational staff and deem that definitive of integration. It's basically premised on a philosophy that the agency I work for holds resources for the community. We don't own those resources.

There are many examples of service integration and a great deal of recent literature and policy documentation from government on this topic. Despite that, it's my experience that there's tremendous resistance to the concept. The idea that services, mandate and function and resources should be shared seems somehow difficult to achieve. I'm quite concerned that without some further achievement in service integration in a systematic, ministry-directed examination of services to children at risk, the system will basically expense itself beyond capacity and beyond the willingness of the public to pay for it.

There are a couple of examples I'd like to briefly reference that speak to service integration. For example, integration of family-based agency foster care resources with private home day care would tremendously expand the pool of community resources available for day care. That's more particularly true in rural areas, where institutionally based centres are sometimes very difficult to access. The segregation of day care from the services stream, in my opinion, only enhances the increasing probability of at-risk children entering school and failing, and failing very early.

Another example: The integration of child witness preparation programs in crown attorneys' offices and child protection efforts in societies through joint funding would enhance the successful prosecution of abusers and the effective treatment of abused children, and there are demonstrations or examples of that particular model in a couple of areas of the province.

A third: The integration of prenatal and early postnatal care services in child welfare with those offered by health units would early identify risk, would intensify services and to some degree would integrate the mandate of child development with that of child safety.

Another example: The integration of vast portions of the children's mental health and child welfare service systems through single case management, commonly accessed foster care resources, for example, and full utilization of jointly held resources would, in my opinion, dramatically reduce service duplication, and there's a great deal of it, and contribute to the equitable distribution of dollars across communities.

I wonder in this brief why a family should have to shift agencies, which effectively means shifting systems, because a child or a family requires temporary care in a foster resource owned by a CAS. That would perhaps be the case if that client started out in a children's mental health centre and required some form of temporary care.

Another example referenced earlier by my colleague: The integration of family violence and child welfare services really would respect the reality that domestic assault can't be isolated from child maltreatment. That a police officer refers a domestic matter to a women's shelter, to a children's mental health centre or perhaps to a child protection agency and then hears nothing until the next occurrence is in my opinion cause for concern.

Service integration isn't a simple amalgamation of agencies and of their governance structure. I think that's a misnomer. The solution to the complexity of services and the proliferation of agencies over the past 10 years does not address the service dilemmas which really have been created by public policy. The service system, or as some would say non-system, is really a creature of public policy, and resolution of current problems will result only if strongly placed interministerial venues are given the mandate to be innovative and to create new service structures.

In my opinion, the child welfare system for which I work is quite ready for change, and I think it's to a large degree a potential leader. It's a system that sees quite frankly probably the most vulnerable and many of the most disadvantaged children and families in the community and it's quite committed to some significant restructuring.

In conclusion, I might suggest there's a need for a couple of things:

One is innovative funding directed exclusively at children's services, funding which includes the day care system, but funding which is designed to achieve inter-system service integration. That's involving health care, education and social services.

Another suggestion is that there's a service requirement stipulating that children's mental health and child welfare agencies, the two larger systems really in the social services children's system, systematically explore service integration, including common data collection, joint residential occupancy, joint case management and outcome measurement research.

Finally, the creation of ministerial strategies in addition to broadly based frameworks might serve to better guide boards of directors in these various systems, many of whom are quite confused about future roles and future mandate and how they might save money and achieve efficiencies by combining, amalgamating or, as I suggest, integrating their mandate and some of their services.

All this being said, in the concluding paragraph I note that the diversity of the social services system is a strength as well as a weakness. I hope that the solutions which you in the field eventually bring to bear respect that diversity and that indeed we don't see service elimination as a necessary outcome. Thank you for your time.

Mr Bruce Rivers: The Children's Aid Society of Metropolitan Toronto believes that prevention is an essential element in the child welfare service continuum. Prevention programs offer the least intrusive method of supporting, strengthening and empowering families, children and youth. We see them as essential to supporting Metro CAS's goal of keeping children and youth safely at home and in the community, thus preventing admissions to foster or residential care.

Not only is this the preferred way to serve children and youth in our community but it's also the most cost-effective. For example in 1993, we know that the average cost of providing service to a child or youth in the care of our agency was approximately \$1,500 per month,

while the comparative figure for providing service to a child or youth in their own home was \$94 a month.

1610

As you may know, there has been a continual debate as to whether or child welfare should be in the business of prevention or should simply stick to protection. We respond to the debate by pointing out the following:

To draw an analogy, it is critical to address the smoke and the fire. Our mandate and responsibility is to not only address individual cases of child abuse and neglect in order to protect children and youth but to also address the root causes of these problems in order that steps can be taken to prevent child maltreatment in the first place.

Secondly, child welfare has a community presence. It is one of the few remaining service sectors that visits families within their own homes and communities. We call that a home visit. Providing community-based social work enables child welfare professionals to assess community trends and issues affecting the families they serve, particularly those that place families under the kind of severe and prolonged stress that causes family breakdown.

In an era of service integration, it makes no sense to fragment child welfare protection services from prevention. Prevention programs complement the child protection mandate as they reduce risk factors for children, youth and families by providing more supports in the community. The intent is to reduce the risk of maltreatment, strengthen their resistance and promote a sense of competency by helping the community to develop the skills and resources required to improve the quality of life and reduce the risk factors that we know contribute to their maltreatment. By risk factors, I am referring to poverty; poor housing; homelessness; unemployment; social isolation; single parenthood, especially teen parents; substance abuse, especially crack cocaine, as well as mental illness.

Metro CAS's belief in prevention and early intervention as part of the continuum of child welfare services has been operationalized within our agency for many years now through a variety of primary prevention, early intervention and family preservation programs.

In addition, 15 years ago the board of directors of the society, recognizing the community's responsibility to address the growing problem of child maltreatment, established a foundation. Today the Children's Aid Society of Metropolitan Toronto Foundation raises approximately \$1.2 million a year in the private corporate sector, which it annually grants to child abuse and neglect prevention projects in a variety of geographic, ethnoracial, first nations and other communities of interest across Metropolitan Toronto.

Many of the funded projects have benefited from the involvement of the six community development workers who are employed through the children's aid society. These funds are startup only, and I want to underline that point, because sustaining responsibility must be built into the core operating budgets of agencies like children's aid societies.

Now I'd like to bring some life to the concept of

prevention. A list of projects has been provided in your package, but I would like to speak to one in particular. It's called Babies Best Start, which was initiated by the Metro CAS Scarborough branch and developed in partnership with a number of other child-servicing agencies in Scarborough, such as the Catholic children's aid, the Metropolitan Toronto Housing Authority, Scarborough public health, the preschool Discoveries Child and Family Centre, Rosalie Hall maternity home, Bethel maternity home and Cliffcrest Parent-Child Centre, as well as with a lot of involvement from community volunteers.

The program is designed to use early intervention activities and parent education to promote the optimal potential for growth and development of new and/or isolated parents and their infants. The anticipated outcomes are many, most importantly the reduction of infant mortality; a reduction in low birth weight; the promotion of childhood physical, social, emotional, behavioural and cognitive development; improved parenting capacity; a reduction in child abuse; improved school readiness; greater access for families new to Canada to existing resources; and building the community's capacity to support parents during the prenatal to school-age period.

There are three components to this program that I'd like to reference. Together, they help to minimize the risk for children and they create jobs for women who need them. The first piece is the home visitor program, whereby parents from the indigenous, local and ethno-racial community are recruited, trained, supervised and paid an hourly rate to carry out a friendly home visiting service to new parents living in Scarborough.

The second piece is the Nobody's Perfect program, a six- to eight-week parent education program designed specifically for isolated, at-risk new parents. The final piece is the Mother Goose program, which over a 10-week period uses nursery rhymes and games to enhance parent-child communication, enjoyment and bonding to promote motor development, the child's communication skill development and an early appreciation of reading for pleasure and personal development.

The home visitor program is a voluntary, friendly, flexible and non-intrusive service that involves building a trusting relationship with parents and helps to inform and teaches them about infant growth and development, stimulation, nutrition, health and hygiene, safety, women's issues, sex education, understanding and adapting to Canadian culture and child-rearing practices, and how to access community resources.

The results of Babies Best Start in preventing child abuse and neglect have exceeded our expectations. It has received national attention and acclaim. This program, which was created by the CAS, has been passed over to the community and has received ongoing funding of approximately \$400,000 a year through the federal Brighter Futures program.

The best persons to give testimony to the program's impact are the users of the service. In the following video clip, you will hear from one of the young mothers about the benefits she has derived from having a home visitor in her life. It's important to note that this program has

responded beautifully to the diverse needs of the Scarborough community through its efforts and the 20 home visitors who have been specially trained and are capable of delivering service in 30 different languages. If we could have the video please. I'd like you to meet Donna and Lorna, who are home visitors, and Cathy.

Video presentation.

1620

Ms McConville: We'll conclude with some recommendations for the committee:

—That the government make children and youth a priority on the public policy agenda. The views of children, youth, parents and service providers must be considered when developing public and policy positions. The entitlements of children as articulated in the Children First document and the UN Convention on the Rights of the Child must form the foundation of public policy that impacts on children and families.

—That children's entitlements be merged into the best interests section of the CFSA.

—That all political parties affirm and support the implementation of the recommendations made in the Premier's health council document Yours, Mine and Ours.

—That the government take a lead role with other partners in a public education strategy that is directed at negative attitudes towards children, reinforces positive parenting and encourages community support to the parenting role.

—That public funding policy support a spectrum of child welfare services that include remedial services and services directed at the prevention of circumstances leading to child maltreatment.

—That families in every CAS jurisdiction have access to alternate measures of dispute resolution, such as mediation, and these be incorporated into the rules of procedure for the Ontario Court (Provincial Division) and be the first course of action in non-consent proceedings.

—That government proceed with the outstanding amendments to the CFSA and support a legislative amendment to allow child protection intervention for children who live in families where family violence is substantiated.

—That the "least intrusive" principle now contained in the CFSA be modified to include language which values decisive intervention with children and families at the earliest possible age.

—That the government amend the CFSA, consistent with the UN Convention on the Rights of the Child, to ensure protection and substitute care to children who require it up to 18 years.

—That the government transfer the jurisdiction and funding for young offender services to children between 16 and 18 to the Ministry of Community and Social Services. Diversionary approaches and alternate measures are needed to support the intent of this legislation.

—That public policy and government structures be developed to facilitate service integration, interministerial collaboration and a pooling of resources to ensure equal

access to public services for all children in Ontario.

—That a provincial fund be created to finance new strategies that promote the health and wellbeing of children and support primary prevention and early intervention programs directed at children at risk.

—That government ensure that all ministries share responsibility and are accountable for the health, wellbeing and transition to adulthood of those children entrusted to state care.

—That a report card on the wellbeing of children in state care be developed and implemented.

—Finally, that a review of the full spectrum of services available to children at risk, and funded by all ministries, be conducted to identify service gaps and barriers to the integration of services.

Thank you. That concludes our presentation.

The Chair: Thank you. In the time we have available for questions, we will in no way be able to do justice to all of the thoughtful ideas you have presented. We will take all of these ideas and be considering them, but let us try, at least for a few minutes, to get into some dialogue on some of the points. We'll begin with Mr Owens.

Mr Stephen Owens (Scarborough Centre): I'd like to address my comments to Mr Rivers. I had the pleasure of touring Babies Best Start and I met with some of the moms and the kids and the providers. I share your view, that it's such a pragmatic, commonsense approach to providing moms and dads with the kinds of skills that they need to give baby the best start.

I was further impressed by Roscoe the Bear, which sits on my credenza at home. For those who haven't had the pleasure of knowing what Roscoe is, Roscoe is a toy bear that's been designed to provide for maximum tactile stimulation so that there's that touch, that stimulation that the child needs to thrive. I appreciate your comments on that and they're quite true and I continue to be impressed with the program today.

In terms of amalgamation and, I guess, rationalizing in the positive sense the services that are provided, I have just a bit of concern with respect to putting this service into the educational system. If you speak to constituents and your neighbours, the one thing that people will agree on is that the educational system doesn't work, that it needs changing. Our minister, Dave Cooke, is in the process of trying to determine ways with the royal commission of how we can do that without reinventing the wheel.

I'm wondering where you see the accountability of a system like that. If we put it into the educational system, what would be your expectation of the teachers? There are currently programs that are supposed to identify children at risk, but it's been my experience that the level of efficacy is clearly dependent on the motivation of the teacher, the principal, the parent or the parents. How do you see that kind of a system working?

Mr Rivers: Thanks very much, Mr Owens. We were delighted to have you as a guest at Babies Best Start. I'd like to extend a similar invitation to other members of the committee. Any time you'd like to join us, we'd love to have you.

To begin with, I want to make a comment about the program Babies Best Start in that we would not see that particular program necessarily being integrated with the education system. I think that part of its success, quite frankly, is based on the fact that it's been community-owned and community-driven at a very basic level by the mothers who live in the housing developments that have been targeted throughout Scarborough.

However, I think there are other members of the committee who could speak more effectively than I to some current initiatives with the boards of education. My only comment, based on my experience in Toronto, is that as education systems are currently configured your comments are right on. I don't think the investment would work. We have to rethink how education is offered and how the community itself can participate in the delivery of education and create services that can support families and children at risk through that system. Mary or Jerry might have something they'd like to add to that.

Ms McConville: I don't want to speak on behalf of Mr Muldoon, but I don't think Mr Muldoon's intent was to suggest that the education system completely subsume child welfare. I think we were using that particular initiative as an example of how specialized services can become linked more closely to mainstream services. Mr Muldoon's agency is still a child welfare authority that has to link to a whole variety of community programs and work collaboratively with them, only one of which is the education system. But I think it's a good and innovative model in terms of how—

Mr Owens: The question is, where is the point of access? Who acts as the gatekeeper, is my question.

Mr Muldoon: In practical terms, the gatekeeper becomes resident in the school. It might be the social worker who is assigned full-time to Walter Zadow school in Amprior by the agency. Gatekeeping becomes, in my opinion, a shared task in the sense that these child welfare people and these educators begin to develop a common sense of child protection and a common sense of child safety in a school, probably at a much earlier stage than might normally be the case. I think it becomes very much shared. The reality of the experiment or the demonstration to date is that, with that gatekeeping, one is then able to deliver the services directly from the school. I'm not sure that I understand the dilemma.

Mr Owens: In terms of the system as we know it today, it creaks along and turns out "graduates," and everybody agrees that it needs changing. Given that, I'm concerned about where the accountabilities are. Who will be accountable for that child ultimately if we move that into the system, if we move some services or whatever services? I understand that you're not talking about moving everything into the educational system, but where will the accountability lie? As a parent, whom will I call?

Mr Muldoon: I think accountability has been a problem in the system because case management has been a problem. Who is responsible for a case throughout the duration is a constant complaint that comes from the people who use our services, or educational services, for that matter.

In this particular project, the accountability is via the

social worker in the school, who assumes the case management responsibilities through the duration, whatever length of term is required to resolve a difficulty that's brought forward. The case management never changes. Under normal circumstances, a social worker in a school would transfer case management to a mental health worker, who subsequently might transfer it to a child welfare worker. In the process of referral, quite frankly, many of the services break down. This particular model attempts to integrate the case management along with the services.

1630

Mr Ron Eddy (Brant-Haldimand): Thank you very much for coming and giving us very important information on children's services at a time when the need is very great and getting greater all the time. The needs of children and families are so very important. I appreciate hearing about the several important special projects you're getting into. I expect you have a clearinghouse, so to speak, to tell each other about it and get into different areas.

Unfortunately, the need has never been greater at a time when funding restrictions are getting more crucial. I want to talk about the funding. I know that many children's aid societies, if not all, experience shortfalls in income to be doing the things they are mandated to do, without the extra things you're working so hard to do.

I don't know whether the funding system is included under number 3, but I understand the present funding system is what could be termed a mess. It should be changed and improved, and how do you see that? Because that is the basis of the service, isn't it?

Ms McConville: That's something we're presently negotiating with this ministry, but we've also been negotiating this with the ministry for years now, and other governments, and don't seem to be making substantial progress. I think one of the barriers has been a lack of clarity about the role of child welfare, and that's one of the reasons we've chosen to speak so clearly to that today and at such length.

The old funding policy and funding mechanisms or processes to get money to children's aid societies have not really supported the kind of service delivery structure and mandate that we're trying to describe for you today.

With respect to what can we do about the funding pressures, what we're trying to say very clearly is that this kind of service delivery model is a heck of a lot more effective and less costly than a model that forces us to move in with too little, too late. The mandate that restricts children's aid societies solely to intervening with the highest-risk families at the latest possible moment is the most expensive and least effective service delivery model for child welfare. So we're not saying we're going to need a massive infusion of funds to support the demand. We're saying that public policy needs to reflect the broad strategies that are laid out in Yours, Mine and Ours to ensure that more children get a better start. With respect to children at risk, we need funding policies and public policies that support this model of service delivery instead of the old model of service delivery.

Mr Eddy: And you've noted that the expenditure funds for children and families is an investment?

Ms McConville: Absolutely.

Mr Tony Martin (Sault Ste Marie): I wanted to talk to Mr Muldoon, because I am certainly interested in the model you present. I don't know how you got there, to be honest. My experience in my neck of the woods, which is northeastern Ontario too, Sault Ste Marie, is that it's really difficult to bring people together even within the same ministry, never mind bringing ministries together. There's a lot of resistance, even where the ministry itself is interested.

I've worked with folks over the last three and a half years, and I was on the social planning council before I got here, trying to integrate and have people working together. There's still a tremendous sense of territory out there. To get where you are, even if the government gave its blessing, would still, in my mind, take years and be really difficult.

I have a couple of examples in my own area. When I first got this job, we were trying to amalgamate two associations that were delivering services in Algoma to the developmentally handicapped. It's now almost four years later, and I think we finally got to it; April 1 was the date. But I inherited that. It took us four years, and now we're doing it. It's such an arduous task.

I sensed in your presentation that you were laying some of the blame or the blockage on the ministry and the government. I suggest to you that my experience has been that the ministry wanted to do it, but they can't get the folks down there in the communities to get it together and start to work together.

Mr Muldoon: The ministry will advise the field that indeed the planning should take place in the community, that the community should look after itself. No one could dispute that. We in the community will look at the ministry and suggest that we need some more decisive position taken by ministries; we suggest strategies rather than simply frameworks. We tend, perhaps, to sit and blame each other.

The experiment I described was driven in large measure by issues of quality, not by issues of finance. It's been my experience that with the current climate, we see a real retrenchment rather than a willingness to innovate, at a point in time when, if we ever needed innovation and restructuring, it's probably now.

I credit two innovative and creative directors of education in the county who were willing to risk the image of child welfare in their schools because their primary concern was for good, quality service and their concern was for partnership. With those themes, this kind of service model emerged.

Quite frankly, and I don't know whether my colleagues would support me, there are days when I wish the ministry was a little more decisive and a little more willing to invest in innovation, as Mary suggested.

Mr Rivers: I'd like to add to Jerry's comment that there's an opportunity here for the committee to make a recommendation that would be very practical and would bring about change; that being that funding to players like

ourselves, to boards of education, be contingent on people working together differently. I think then you're going to see the behaviour start to change. It's very simple: Make the funding contingent upon a different way of doing business.

Mrs Yvonne O'Neill (Ottawa-Rideau): This has been an outstanding presentation. I particularly like the last four recommendations you made. I think those are fundamental. I hope in my lifetime I will see those.

I wanted to ask you a couple of things. First of all, is this philosophy that you bring today right across the children's aid societies, or may I ask very bluntly if this is your best face shown? I've met with other associations that have a different attitude about collaboration, particularly with children's mental health. I have to ask that question, just for the record.

Ms McConville: I think it would be fair to say that the approaches to service delivery that you've been exposed to today could be described as the best and most innovative and, we believe, the most effective kinds of service delivery that you could see come out of a child welfare authority. But I also said in my presentation that the service delivery was not uniform across the province and gave an indication of some of the reasons.

There's no question that we've got funding inequities. There's no question that we've had ongoing and chronic debates with the ministry about the role and the interpretation of the mandate under the legislation, despite the fact that we've been able to demonstrate over and over again in many places through these kinds of programming that this is a more effective use of the public resources and in fact a very legitimate role for a child welfare authority to play with respect to high-risk children. But we haven't had a rational funding formula, we haven't had consistent public policy support with respect to the interpretation of the legislation, and that's in part what we're trying to negotiate with the government.

1640

The other thing that needs to be said is that the resourcing for this kind of breadth of programming has to cut across ministries. We've talked many times, if you notice, about the pooling of resources. We've got day nurseries' funds present here, we've got federal grants present here. If the government wishes to support this kind of service delivery model for services to families and children whom we would refer to as high-risk, we have to think more creatively about how to fund those programs, and the MCSS dollar is not the entire solution. We need some willingness on the part of other ministries and other levels of government to collaborate with respect to supplying resources, both people resources and funding resources.

Mrs O'Neill: I'm very pleased that you've been so practical and that you have really shown what's possible. Are the Babies Best Start program and the mutual aid organizations programs in those cities in some jeopardy at the moment? I have to ask you that again as a very direct question. I know you have mandated services, and these are beyond the mandate or are a different interpretation of the mandate, because I suppose they are not totally reactionary but are much more progressive. I'm

concerned, and some of the other associations I've met with, maybe even some of you whom I've met with, have suggested that prevention is in some jeopardy at this moment.

Ms McConville: It's in jeopardy in the sense that we don't have clear funding policy that supports the preventive role, but it's not beyond the mandate. It is part of the legislative mandate, very clearly. The funding policy is not clear, though, to support that piece of the mandate.

Mr Walsh: It's a matter of what comes in the front door. If more come in the front door than what you're able to accommodate with your existing resource base that goes to mutual aid or day nurseries, promotional kinds of programs, if more come in the front door in terms of straight protection and investigation, you're very much obliged by the funding policy to take it out of the other end of your service delivery. It's really cutting off your nose to spite your face. We've demonstrated, in terms of identifying the clients—and they all are child welfare clients, it's not like it's the general population; it's a child welfare client, it's a family at risk—that unless you serve these people in an empowering kind of way, you're going to be putting the Band-Aids on later on, and very expensive Band-Aids.

Mr Charron: I'd like to make one comment as well about the funding issue. Our day nursery parent enrichment program was in jeopardy. It was originally funded by the regional municipality on a purchase-of-service agreement. The region decided, because of its economic pressures and what they called downloading, to take out its 20%. We were fortunate to get the cooperation and the support of the ministry and go to corporate status; otherwise that program would have been dead.

Mr Rivers: Could I speak to Babies Best Start? As I indicated, the program was initially funded by the corporate community, approximately \$300,000 through the Children's Aid Society Foundation, and is now being sustained by a federal government grant called Brighter Futures. There's no funding currently available within children's aid societies to initiate and sustain the kind of program that we described as Babies Best Start. We would encourage you to make that recommendation.

Mrs O'Neill: Is Better Futures a very time-defined program of the feds, or is it a pilot project? I don't know it; I'm sorry.

Mr Rivers: Sustaining.

The Chair: I'm afraid I'm going to have to be the heavy and bring this to a close.

One of the things that is very clear to me is that we have talked—and when I say “we,” I mean various governments—about the role of the children's aid society, and while the mandate doesn't preclude prevention or the kinds of programs you've discussed, it's probably fair to say that all governments have tended to emphasize the protection part, particularly in more difficult times. When one looks at both the Children First report and then Yours, Mine and Ours, it's how do we get out of that mindset and, together with other players in the field, bring about more of the kinds of programs you're talking about?

Would I be correct in assuming that you are interested in the funds the Minister of Community and Social Services recently underlined, I think \$6.8 million? I was at a meeting of the Metro school board that had a number of people, and they were interested in working together. The minister expressed at that point that school boards, as part of a community presentation, would be acceptable. You'll be looking at that, perhaps, for some innovation?

Ms McConville: Yes.

The Chair: Good. Thank you again for all of these recommendations and thoughts.

YOUTH IN CARE CONNECTIONS ACROSS ONTARIO

The Chair: I call on our next presenters, representatives from Youth in Care Connections: Kim Way, youth program worker, and T.J. Whitley, youth liaison worker. Do we call you T.J.?

Ms T.J. Whitley: That would be great.

Ms Kim Way: We brought Diane Cresswell, the manager of communications, with us.

The Chair: We're always delighted to have her with us at the table.

Ms Way: Just to outline, in our package we have our annual report so you can get some idea of what Youth in Care Connections has done over the past year; a youth discussion paper that was prepared in 1992 that also highlights some of the things we'll be highlighting today; a brief information sheet about Youth in Care Connections; summaries the youth have provided feedback for over the past year, which we will be referring to and taking information out of; and the September issue of *The Journal* highlights youth information on extended care maintenance, which they have been highly involved in.

I'm Kim Way and I'm a former crown ward of the Perth County Children's Aid Society, and T.J. is a former crown ward on extended care and maintenance with the Hamilton-Wentworth Children's Aid Society. We are youth representatives of Youth in Care Connections Across Ontario, which we call Con-X-Ont, just to shorten it a little. It's a network of youth in care of children's aid societies in Ontario.

Con-X-Ont's goals are to identify and advocate for the needs of youth in care; provide input and feedback to interested organizations that are researching programs that affect youth in care; provide support to youth in care, especially those who have had a chance to work with the adults in the agencies; and provide youth with the opportunity to develop, strengthen and evaluate services.

Since the summer of 1993, we have been able to meet with youth from many of the 50 children's aid societies at various conferences and activities that youth have been formed at and we've been able to discuss some of the services youth receive. We've also been able to gather written feedback from youth—and you have the summaries in your packages—through the assignments we have developed to investigate youth issues: their ideas, feelings and recommendations on the issues that other organizations are wanting to hear more about. We'll be presenting information we've gathered from these consultations with the youth, as well as information from our own personal experiences of being in care.

We realize that in a time of economic restraint, there is a priority to keep children and youth out of the care of children's aid societies and that the focus of the dollar may be moving towards reducing support and prevention programs in child welfare. However, it is important to recognize that there is a number of children and youth in the CAS system for whom becoming a crown ward will not be preventable. These youngsters will be cared for by CASs for most of their lives, and for these children and youth another type of support program must be stressed and provided while training them for adulthood.

Training youth for independence means preventing us from becoming dependent on the child welfare system and social assistance programs in the future, helping us become productive members of society, and providing us with parenting skills and resourcefulness that will prevent our children from re-entering the system. I think you will hear in our presentation that some of the recommendations and programs youth are asking for will fit in nicely with the presentation you've just heard.

T.J., you want to talk a little bit about independence.

1650

Ms Whitley: The children's aid society's goals for a child who enters care from any age should be to train and help this child to become a productive member of society who is able to be interdependent with the community and the services it has to offer.

Relying on situations from our own experience of being in care and from other youth we have heard from, we know there are many services that we should receive as we're growing up in care. Services should be provided to us not only in the last few years before leaving care, but should begin and continue from the moment we enter care.

Youth in care who have been removed from their biological families need support and services to deal with separation and loss of the natural family; support and services to deal with the abuse we've suffered while in our natural families; workshops and activities aimed at building self-esteem and confidence; also, there is a need to be able to form relationships that support the learning of social and communication skills that demonstrate healthy alliances and act as resources and teachers.

Youth living in stable natural homes have the opportunity to learn skills such as cooking, cleaning and job skills through family interactions and modelling. Through the family network, youth have resources and gain information such as jobs and skills, housing and much more.

However, youth in care often miss learning these skills because they have not had stable or appropriate relationships due to changes in workers or placements. The service providers often are too busy concerning themselves with our family crisis, school adjustment and our problems with siblings and overlook our need for basic skills to become independent.

For a youth in care, these basic skills are even more important than for a youth who has a stable support system. When a youth moves away from the care of the children's aid society at 18 or 21 years of age, they must

perform simple tasks, such as cooking, laundry and cleaning, for themselves. As well, they must engage in the job search, pay bills and investigate investments for the future. There is no one to do it for them and there is a strong possibility that there is no one to direct them to services that could help them.

Even when a youth has left their natural family, there's always that security and that support system behind them that if there's something they need or if they're short of money that month, they can go back to their family and they have that support system behind them. For a youth in care, once they turn 21, that's it. There is nobody there. It's not the responsibility of the social worker or the past foster parents to be there, to be a support system to them any longer. So it's a very scary thing.

Those youth in care who are able to get the needed supports and services provided to us through the CAS are more likely to become independent and be able to access resources in the community; finish high school and pursue post-secondary education or vocational training; have valuable job skills and be able to find and keep a job; avoid the need to rely on social assistance in the future; be partners in healthy relationships and become nurturing parents; and generally just be more happy, more secure, more productive people in society.

Youth who do not receive the necessary supports while growing up are more likely to drop out of high school; become criminally active; become dependent on social assistance programs shortly after they leave care or immediately after they leave care; live on the streets and become involved in self-damaging activities such as drugs and prostitution; become parents at an early age and be unprepared or unskilled while raising children, therefore returning to the cycle of abuse they were once removed from; and be generally unhappy, non-productive, unresourceful members of society.

Ms Way: Many youth in care do not have contact with their natural families after coming into care. The only support network youth in care have is the CAS, the CAS staff or former foster parents who the youth have been cared for by and grown up with.

When a youth moves out of a foster home to move to independence, the relationship between him or her and the foster parents changes. The foster parents now have a priority to care for the new child or youth who has moved into the home and who has replaced the older child once living there. Youth in care feel this when they move out of the home and a new child moves in, and they're reluctant to go back to the old foster parents because that relationship has changed and the foster parents no longer have the resources or the time and don't feel responsible necessarily to take on that youth who is now living out of their home.

Youth have expressed concern for many years that they feel abandoned and neglected when the CAS removes emotional or financial support when they turn 18 or even 21 years of age. Youth feel that it is at this time in their lives that their future is starting to take shape, when they need the most support and guidance. We feel it is necessary to continue to provide support to youth until the age of 21, and ideally beyond that age, especially if the youth

are furthering their education.

The Minister of Community and Social Services has recognized the importance of CAS support for youth in transition to adulthood. In 1993, the Ministry of Community and Social Services began a policy review on extended care and maintenance which involved both CAS staff and youth in care of CASs in Ontario. After much hard work, sharing of personal experiences and the identification of needs by youth, the minister announced the addition of \$3 million to current extended care and maintenance funds to support youth on extended care and maintenance.

Although guidelines and eligibility criteria still need to be revised, the changes will be put in place in the summer of 1994. Although this service has not been revised to be a mandatory service, youth accept the idea that it will no longer be acceptable to turn youth to welfare upon turning 18, with no support or guidance through the transition to adulthood.

Youth who have been able to receive care from the children's aid society until the age of 21 are grateful for the support but still find themselves with many adjustments to make as they move towards very few support networks. If the youth is continuing school, he or she must face the remainder of school alone. If the youth has finished school, he or she must face OSAP loan debts that may be thousands of dollars, finding and paying for residence, finding a job and paying for basic needs. The youth must deal with this without a home base to work from or to support him or her. In fact, at times, between moves from school to a new apartment, the youth may find himself or herself with no place to live until he or she gets settled.

Just recently, I've had that. I've just finished university and had to move out of my current apartment. Unfortunately, I've had some difficulty trying to find a new apartment in Toronto. I was lucky enough that I had developed an older friend who would let me live at their house for the past month. I kind of crashed on their floor. But for many youth in care, we don't develop those relationships with people who can help us, and we can't rely on friends our own age because they're probably living in their own homes with their parents or haven't even thought about moving out.

Over the past year that Youth in Care Connections Across Ontario has been recognized, Youth in Care in Ontario have been involved in the following consultations: extended care and maintenance; reducing the risk of abuse in foster care; Ministry of Community and Social Services children's policy framework; worker contact and other supports to youth in care; foster parent training, evaluation and disclosure; rights and responsibilities and complaints procedure; residential placement advisory committee; the Royal Commission on Learning. The summaries we have got from the youth are included in your packages, if you'd like to brief over them later.

Youth have been able to evaluate the services they receive as well as to identify services they feel are necessary but do not receive currently.

As one would note in assignment 4 in your package, the assignment called "How Youth and Children Feel

About the Services they Receive," youth have identified the following services that they receive and feel are absolutely necessary: emotional and financial support; independence training; rehabilitation services; probation services; youth-in-care groups, and these groups would be buddy systems or groups that can share experiences and make friends and work on issues of concern; counselling; medical and dental care; sexual and physical abuse treatment; lawyer and court services.

Youth identified that the training and counselling they should receive as they are growing up in care should include cooking, laundry and maintenance skills; counselling and support for separation, loneliness, assertiveness and self-esteem; job skills; skills and information on accessing resources; information and training for housing searches and the Landlord and Tenant Act; budgeting and money matters information such as banking, investments, insurance; communication skills; parenting skills.

These skills are absolutely necessary if we plan on succeeding in becoming independent. With many of those skills, you will note, many of the youth have a chance to learn if they're living in their own homes. Unfortunately, many of the youth in care miss out on some of those.

Youth have said that there is a need for education staff such as teachers, principals and volunteers who work with youth in care to have more communication with the youth themselves and the CAS staff, such as workers, supervisors. Youth feel that by being a youth in care of a children's aid society, there are a number of factors they must deal with while also being a student. Many of these factors affect the youth's ability to learn or attend school regularly.

Along with the normal peer pressure, with drugs and alcohol and what to wear to school, we must also face the labelling and stigma from the other children and sometimes the teachers. Youth feel that changes in placements, family problems—biological and foster family—social worker changes, court and school changes, living independently at an early age, and self-esteem and sense of belonging are all factors they must deal with while attending school.

1700

Youth feel that for the school personnel to help them more effectively, teachers must be prepared to learn more about the CAS and its role in the community and to understand the effects of loss and separation on behaviour. Teachers must also be willing to examine alternative methods for teaching youth who are having considerable difficulties due to being in CAS but do want to learn. Many youth have found that the teachers don't necessarily know what a children's aid society is or what its role is. Then you have the other extreme, where the teacher goes ahead and tells your entire class that you're a CAS kid, which causes an additional problem for youth.

Further, Youth in Care recommend that some of the skills that are being overlooked in current living arrangements be taught in the schools. Some of those skills are social skills, study habits and communications, budgeting, bank rates and investments, income tax, lease and rent information, nutrition and physical fitness, CPR and first aid. In January 1994, this information, as well as some of

the other that is listed in the summary sheet, was passed on to the Royal Commission on Learning.

All youth who are out on their own at an early age identify housing as an issue. Youth in care may not have any other choice but to live on their own as early as 16 years old, due to lack of placement homes for teens. Youth are often discriminated against when applying for housing on the basis of age, lack of references or lack of income. Youth in care again suffer from the labelling and stigma associated with being a CAS kid and many cannot give references, since they have moved out from group homes or foster homes and have never had to pay rent.

Recently, we have found out that many of these have trouble when they try to give social workers' names as references. Many landlords won't accept that. Youth and students often settle on housing that is unsafe and/or illegal because they cannot afford better or they are limited because of discrimination.

Youth in care live on very strict budgets and are disadvantaged. The recommended amount for an independence allowance is \$663, which is the same rate as a single person on general welfare assistance. With housing being so expensive, youth often need to subsidize their allowance with a part-time job to be able to pay the basic bills of rent, food and hydro. The part-time job is something that is invaluable for job skills but may be creating undue stress for a youth who is working towards a high school diploma. Youth need better access to government-funded residence or children's aid societies need to work at creating alliances with home owners for youth to find affordable, legal and safe housing.

Again, housing has been an issue for me. Trying to find something in Toronto is incredible. A one-room apartment is basically \$600 if you want it in a safe neighbourhood and it's well-kept. For somebody who would be receiving extended care maintenance in the upcoming years, receiving \$663, it's not going to cut it. It would be very difficult to share a one-room apartment with somebody else to help with the rent. Some of the places that I've checked out, being around the \$400 or \$450 range, are not in very good places to live and are not very well kept at all. I think T.J. had the same problem when she was looking in Hamilton.

Ms Whitley: Yes. Hamilton is a little bit of a less expensive community. I went apartment hunting and I could not find anything I could afford. I receive less than what Kim just mentioned. I receive \$627 a month. That will change once the minister's announcement goes through and stuff, but at \$627 a month it's very difficult to find an apartment that is in a safe area. I live in a safe area, I did find an apartment, but it's not really suitable. It doesn't have a stove; it doesn't have a full fridge; it's incredibly small. To be in an apartment, you have to have so many square feet. There's not enough square feet in my apartment for it to be a legal apartment, and two people share it; I share it with another girl. You can't find anything in a safe area that's affordable. Anything that is in a safe area, you're looking at about \$500.

Youth have much to offer. Our point of view in our recommendations will be valuable to children who will require care and protection in the future. We believe we

can help. All youth feel that it is important that we be included in the review, evaluation and development for services for children and youth. No one can understand exactly what a youth experiences or needs when they are taken out of their natural homes except for youth who have gone through the upheaval of leaving their natural home.

To involve youth on issues and services that affect youth all over the provinces, Con-X-Ont is one vehicle through which youth in care can be accessed and can participate.

The involvement of youth at the local levels must increase. Over the past couple of years, youth have been hired at their local children's aid society as youth representatives. The youth have been able to gain valuable job skills and work experience while working on youth issues and activities. As well, these youth have been a resource person to Con-X-Ont and children's aid staff.

In the summer of 1993, 26 youth were hired in this capacity in their local children's aid society. These positions were made possible through the summer employment Experience funds of the Ministry of Community and Social Services. It has proved to be valuable to both youth and service providers. Youth need to be able to sit on service committees to the board of directors, on planning groups for independence training and present to new foster parents, and much more. In these ways youth can help develop and evaluate the services which directly affect them where they live.

The changes that are being made to extended care and maintenance, largely due to youth determination and commitment, are an example of youth's input through constructive approaches and sharing personal experiences and identifying personal needs.

We've brought to you today a list of recommendations:

- That the independence training programs be made available to all youth in care, from the entrance to care until graduation from care.

- That ministries of government that provide services to children and youth, such as the Ministry of Community and Social Services and the Ministry of Education and Training and others, work together to understand the role of children's aid societies and the needs of youth in care.

- That the Ministry of Education and Training consider former wards of children's aid societies as a priority group for forgivable loans through OSAP.

- That the Ministry of Community and Social Services continue to work on phase II of the policy review of extended care and maintenance to review, to develop and to fund appropriate support services for youth in care.

- That the Ministry of Community and Social Services and the Ministry of Housing work together to create housing that is safe, legal and affordable which is easily accessed by youth in care.

- That the government and its respective ministries providing services to youth at risk continue to consult with youth in care in the review, evaluation and development of services for youth at risk.

- That the government provide job incentive programs and provincial funding for jobs for youth at risk.

Ms Way: If you have any questions, feel free. We'd just like to take a moment to thank you for giving us, the youth in care in Ontario, this opportunity to be able to present to you today.

The Chair: Thank you, and thank you as well for the additional documents that you've brought with you. We'll move right to questions.

Mr Owens: Ms Way, I believe you testified before this very committee approximately four years ago on the issue of children's mental health services, and I'd like to welcome you back. Some things have changed and some things have not changed for the better in those four years.

I guess my question is that you reference a little bit—not a little bit, significantly—in terms of the process by which financial assistance is accessed by youth in care and youth as a whole. It's my understanding that there are some pretty horrendous experiences out there in the community.

I do a lot of work with community legal clinics in Scarborough and across the city on poverty issues, and they've told me—again, there are some fairly horrendous experiences that have happened to young people 16 years of age who are trying to access general welfare assistance, for instance—that even children where there's suspected sexual or physical abuse are still made to go back to the abuser or the parent until the children's aid comes in and removes the child to get permission for that financial assistance to be granted.

Can you comment on that? Is this a widespread problem? Is it perhaps a local office problem?

Ms Way: I don't hear too many of the experiences from youth in care in respect to welfare, but youth are at a disadvantage in anything. They need help from many service providers, and when they are 16 to 18 and beyond, they try to access wherever they can and unfortunately they are taken advantage of because they don't know the ins and outs of the system.

1710

Many of the youth we deal with at 18 turn to welfare because there isn't any financial support within the agencies to support them. There is a discrepancy in some agencies as to whether they can take the youth in at 16 and 18 to give them any prevention services. I could see very much them being taken advantage of at the welfare offices.

Mr Owens: You mentioned also the issues with respect to the educational system and the fairly significant problems that young folks like yourself have within the system around confidentiality and understanding by the instructor in the classroom. Can you tell me what kind of recommendations that you made to the royal commission on this issue in terms of teacher training, teacher sensitization?

Ms Way: I will tell you to refer to the assignment 4 in the summaries, in the green sheets. Different recommendations came out from the youth that have worked. They would really like that somebody from the CAS staff, preferably the worker of their case, be in contact with the principal or one of their teachers in the school but that the youth be involved in the discussions and that

it be flexible, that not every case would be handled the same. The youth in care would be able to say whether they would like the teacher to act in a certain way or to provide special assistance to them.

But the main thing was that the CAS and the education staff have more communication, because many of the youth felt that they weren't having enough, and that youth be involved and that youth be given the opportunity to say, "No, I don't want to be involved." Each youth is different. But the communication clears up a lot of different things.

Ms Whitley: I actually wanted to add to what Kim said on your first question, about youth being taken advantage of at the welfare office. When you leave care and you go to the social assistance office, it's a very intimidating experience. You've only been under the care of the children's aid society your whole life, youth in care, and then you go to this office.

You don't know the ins and outs of this particular organization; not only that, it's a different process. It's very impersonal, and with the children's aid society, when you go to them, you have a social worker. It's very, very personal. But when you go to the welfare office, it's very impersonal and can be very intimidating, and you could very easily be taken advantage of.

Mr Owens: In terms of recommendations that you would make to the minister with respect to accessing services like GWA, would it be fair to say that you would like to see some kind of a fast-track system, some kind of a bill of rights for youth or just some kind of understanding of what your rights are as a citizen of the province, whether you're 16 or 66?

Ms Whitley: Hopefully youth won't have to access GWA, because with extended care and maintenance to the age of 21—we'd like to see it to 24—you can get an education and you can go out there and you can get a job, so that you're not in a position where you have to go to GWA. That's what we would like to see more than anything else.

Ms Way: To expand on that with T.J., what we would ideally like to see is that general welfare assistance in the community be referred through the children's aid societies, so that the youth get that emotional support along with the money, so that they have the guidance and the resources to access other things in the community, so that they're not just being handed a cheque and nobody's really concerned about what's happening to them in the community, whether they're actually living in a home or whether they're in an abusive situation, but that they be able to work with the social workers of a children's aid society, if they want to, and be able to access other resources as well if the agency cannot provide them funding.

Mrs O'Neill: I want to thank you both for coming. I think you can be very proud of your presentation. You have done quite a bit of work in groups since 1993, and I've been reading some of the results of some of that. Again, I think that's been very helpful, and you definitely are learning very well to articulate what you think the main needs are.

I wonder if you'd say a little bit more about the housing, particularly your recommendation on the housing. Is the kind of housing you are looking at here housing that some people would call shelter allowance or others might call supportive housing or others may call just plain public housing? In other words, do you see yourself as getting your rent basically subsidized or do you see the housing being provided directly for people in your circumstances?

Ms Way: I think that works. It can be flexible. The youth in care we have talked to around the housing issues are willing to work on something that is within their community. There have been a number of different things.

There have been in a few children's aid societies—I can't say the names right off the top of my head, but there have been some agencies that have bought a house or an apartment building or have worked something out with them that as the youth move through independence, they are moved into a semi-independent situation where they're in an apartment building or they're on a floor of an apartment building or they're in a house and the rent is geared to what they're making through part-time jobs as well as what they are receiving on independence allowance. One of the superintendents per se in the building would be a worker or a former youth who is willing to work with some of the youth on independence training.

Then there are other youth who have said that they would like to live in public housing, and sometimes that means we would hope that some of the basement apartments and things would be legalized and that they are kept up.

I think you have other committees that would probably talk to you about that. I think it's flexible for what the youth want, but we need something that is safe and affordable. Some of the youth have really liked the fact that moving into a house that still has some connection with the children's aid society, but not quite as much, is working well for them. Pape adolescent resource centre here in Toronto is one of those services that has offered, as well as other agencies throughout Ontario.

Ms Whitley: Actually, at the Hamilton Catholic agency there is a building with affordable housing. It's all affordable housing. They have two units, and then they rent it out to their youth in care.

Mrs O'Neill: So that's the kind of thing you're thinking about.

My last question—I have many more but we're being quite limited today—do the job incentive programs tie at all in with the Futures program, or is it much beyond that?

Ms Way: We haven't explored the Futures program, although there have been youth in care who have been able to work into that. What we have been working with is the summer Experience—

Mrs O'Neill: That sounds very good.

Ms Way: —and different ones throughout the year part-time. We have worked with the ministry along that, so we've been able to get some funding and that through

the area offices and the youth have been able to work right in the agencies. So that's the one we've been working with. We haven't explored Futures yet.

Mrs O'Neill: You think that kind of thing should be expanded then. That's what you're saying?

Ms Way: Yes, I think so, because many youth can't get job experience through their family, because it really is becoming a time of who you know and not necessarily what you know. A youth who is living in a foster home or a social worker's doesn't have those links necessarily. This way, if some of these programs can be expanded through the children's aid society, they have some of the children's aid society staff that the youth are familiar with and the workers can oversee the program and oversee the jobs and provide youth with correction and some critical reviews on what they're doing, as well as providing them with job experience that will be useful outside children's aid land.

Mr Randy R. Hope (Chatham-Kent): Listening to the presentation—and I have close alliance with youth in my own community—you've talked of larger centres versus the rural, smaller centres. My close relationship is with Transition House, which deals with a lot of kids, a lot of youth, in this process.

The difficulty I always have is the communication with the broader public on the issue of youth. I hear everything from youth wanting to get pregnant and go on welfare. I hear about creating situations in a family that don't exist, and then a way of getting out of the house is going to the children's aid society.

We talk about the linkage between the education system, the CAS and general welfare and all those communications and the number of walls that are going to be difficult to tear down because we face turf protection on that issue. Housing and everything else all have their own little administrative bodies and they love to keep them but they don't want to surrender opportunity.

The biggest difficulty I find in relating to the youth issue is the communication to the broader public, to the adults who are out there saying, "Well, this doesn't exist in my community. They just don't like the rules," and so on. How do you penetrate that end of it? I hear, "We're the involvement of the youth," but I'm wondering how you then communicate to the broader public who are sitting there saying, "You shouldn't allow the youth who have access to welfare to go out on their own. They just want to be with their boyfriend," all the comments that are usually generated.

In small-town Ontario they know as soon as you apply. It's right out there in the broader community. Those are issues that I'm being faced with as an elected member because everybody says, "Where do they go?" In Kent county they know the first place to call is Randy's office and he'll be able to link them to access to permanent housing and that. It just seems like it's normal. But it's the broader public that I have difficulty explaining situations to. I've been in some very serious situations with young people who have been sexually abused and trying to balance that out. I just wanted your opinion about that.

Ms Way: I come from a smaller community as well, from Perth county, which is Stratford. Actually, I was raised just north of Stratford in a smaller town.

1720

What I would say for communication is that many youth, and not all youth, are not able to communicate their needs, but if you can bring in youth who can communicate the needs of themselves, as probably some other youth, they could probably say what you've been trying to say and it's coming from a personal perspective.

We think that many of the service providers are trying to do their best to look after us and to provide our best needs but, unfortunately, sometimes it takes us to say it. I think wherever you can involve youth in the broader spectrum of informing the public, do so.

The Chair: I'm sorry that we have to bring this to a close, but I do want to thank you both for all the time and effort that you've put into the presentation.

SUSAN BRADLEY

KAREN TATARYN

LORRAINE ADAM

ELLEN ROSEN

The Chair: Our next representatives who are from three different children's hospitals: Dr Susan Bradley, who's the chief of psychiatry for the Hospital for Sick Children in Toronto; Karen Tataryn, director of social work for the Children's Hospital of Eastern Ontario in Ottawa; Lorraine Adam, director of social work, and Ellen Rosen, senior director of nursing, who are with the Victoria Hospital, the Children's Hospital of Western Ontario. We welcome you all to the committee.

We have received a number of documents from you. Perhaps I might ask Dr Bradley how we will proceed and just in what order, and if you would each, the first time you speak, be good enough to identify yourselves for Hansard.

Dr Susan Bradley: I have to admit that we are not organized, so I don't think there's a rational order.

The Chair: It doesn't have to be rational. We do a lot of irrational things in the Legislature.

Ms Karen Tataryn: I'd be happy to begin. My name is Karen Tataryn and I'm director of social work at the children's hospital in Ottawa. On behalf of the children's hospital, I certainly want to thank you for the invitation to present today at the standing committee on social development.

The Children's Hospital of Eastern Ontario, as all of us are, is witness at first hand to the vulnerabilities of those children at risk on whom the standing committee on social development is focusing its attention.

As a children's hospital, our health care teams at CHEO provide tertiary level care, prevention and treatment programs for our region's most seriously ill, injured and disabled children. For children who are victims of sexual and physical abuse, CHEO offers a place of safety and a chance to heal their wounds. Our mental health services offer urgent care to children with serious mental illnesses.

In all of these situations we try to provide our care in

a family-centred way, offering our support to families who frequently feel unbearable emotional stress. We strive to empower our families to join the health care team in our decision-making process.

We provide our care in partnership with other community institutions and agencies, and optimally parents, hospital and community will truly be partners. We'll be called upon for tertiary care experience. The service spectrum will be broad, sensitive to need and coordinated. Parents will be active participants in their children's care. Increasingly, however, we find it difficult. Ourselves and the entire system find ourselves to be sorely tested in our capacity to best serve and protect our region's vulnerable children.

Our observations about why this might be so:

As our resources diminish, community programs, hospitals and institutions alike re-examine their mandates and their mission statements. Financial restraint and cutbacks have forced a retreat to an increasingly focused and rigidly defined mandate. The system has therefore lost its flexibility and hence its capacity to prevent vulnerable children from falling between the widening cracks.

The care system for children lacks coordination. It's difficult to enter and it's difficult to navigate for families, agencies and hospitals alike. At any one time, in looking to discharge a child with complex needs from the hospital, CHEO may enter discussions with many of the seven different provincial ministries that have programs serving children.

The care system is struggling to meet current needs at a time when organizations such as CHEO are identifying new needs. HIV-infected children with complex psychosocial needs and technologically dependent children who live at CHEO are two examples.

We've developed a range of prevention and treatment programs directed towards children most at risk in our community. The issues which we have noted in the presentation affect our programs in worrisome ways. They restrict our planning efforts with the community and they certainly limit the number of children we can serve.

I'd like to very briefly give you a summary of just two of the programs that we have at the children's hospital, the school refusal program and our child protection program. In closing, we'd like to make one recommendation about the service network for our most vulnerable children.

The school refusal program: In presenting this particular high-risk intervention program, we realize that it goes somewhat beyond your committee's definition of "at risk." Instead this particular program targets a group of emotionally troubled adolescents who are at such high risk that they've already embarked on the slippery slope towards dropping out of life.

There is a group of school dropouts, predominantly adolescents, that demonstrate school phobia or school refusal associated with a complex constellation of factors. In adolescents, school refusal may be associated with many features, including separation anxiety, family dysfunction, medical condition, a predisposition to psychiatric disorder. Intellectually, this particular group of school

refusers most often falls into the average to bright range. In general, they're quiet, anxious, depressed, withdrawn youngsters from families with similar characteristics.

In general, the group of children who seem to get most resources are those who make the loudest noise, they being the externalizers, the most acting-out children. Hence, the quiet and withdrawn student population often slips away within the school system.

In response to a perceived need, the school refusal program was developed five years ago in the department of psychiatry at the children's hospital. The program has been developed particularly to meet the needs of adolescents who demonstrate the above-described symptomatology. School refusal within our population has been associated with anxiety disorders, depression, reaction to multiple or significant trauma and psychosis.

I'm just looking for the highlights. Within our hospital, we've created a warm milieu, such as a one-room school-house with all of its proven merits: the integrity, flexibility and individualized psychoeducational approach which permits the student-patient the opportunity to enjoy a corrective educational and emotional experience.

A program of this type for high-risk adolescents with its emphasis on reintegration and getting back on track is not only highly fulfilling for individual students reaching their potential, be that academic, object choices or social interactions, but is extremely advantageous to society both in terms of the adolescents' potential contribution to society and in the considerable cost savings to the welfare system for several years to come.

Our child protection program: Since it opened in 1974, the children's hospital has recognized the need as a centralized paediatric facility for a coordinated approach to child abuse and neglect. In close cooperation with the children's aid society, a child abuse consultation team was established. In 1979 our program was established.

The program has seven key elements, and I'll outline very briefly the key elements: identification of children at risk and the detection and management of all abuse cases; medical assessment, documentation of injuries or neglect and treatment and follow-up; psychosocial assessment and follow-up treatment services. I'll speak for a moment about that.

The impact of sexual victimization of children is both immediate and long-term. The therapeutic services offered at CHEO provide boys and girls, children and adolescents, the opportunity to work through their feelings about being sexually abused in a safe environment. Children and adolescents need to regain a sense of control over their lives, enhance their self-esteem and develop ways of coping with the trauma which has occurred. We offer both individual therapy and the opportunity to join structured therapeutic groups.

1730

The group program for adolescent girls who have been sexually abused is innovative and highly therapeutic. The exploration of such issues as body image, sexuality and staying safe within a group setting has proven to be a powerful tool in the recovery of these young women.

One of our new initiatives within this program is the

development of the sexual assault acute care program within our emergency department to offer immediate care for children and adolescents who have been sexually assaulted.

In closing, we'd like to offer sincere congratulations to this committee for attempting to tackle an issue of such fundamental importance. Our youth are clearly our future, and securing their future by protecting their youth and ensuring their entitlements is therefore critical.

While we applaud your focus on this subject, "talking the talk," we challenge the committee to actively implement your recommendations, to really "walk the talk."

We make but one recommendation which has to do with integration of services. Within our local communities, regardless of funding source, all agencies providing service to children and adolescents must work in an integrated fashion, permitting a user-friendly, easy-to-access system which should be streamlined and effectively delivered.

The two CHEO programs presented to you today are programs which intersect with many of the seven different provincial ministries which serve children. There's very little doubt in our minds that an overarching ministry for children would ameliorate, to a large extent, the concerns which we've raised in the earlier part of our presentation.

Dr Susan Bradley: I am Susan Bradley from the Hospital for Sick Children. The presentation which we are making to you today is a collaboration between the director of the suspected child abuse and neglect program at the hospital, Dr Marcellina Mian, the head of adolescent medicine, Dr Eudice Goldberg, the head of support services, Ms Ruth Koch-Schulte, and the coordinator of the infant mental health program, Ms Rhona Wolpert.

Our focus is on families. The dilemmas faced by families are now front-page news. Poverty, unemployment and violence have increased to such a level that we can no longer ignore their impact on families and our children.

Two-parent working families are now the norm as parents struggle to stay even economically, and single-parent families are on the rise. Children experience their parents as less available, tired and often irritable. Few parents can turn to their extended families for support. Parents often feel isolated, having lost a sense of community and having less faith in our traditional institutions such as the government, churches and schools. Immigrant families have the added stress of cultural barriers and isolation.

These dilemmas become even more pressing for families with a chronically ill child. We know that children with chronic illness have twice the likelihood of also having a psychiatric disorder. Their siblings and families often carry a heavy load emotionally.

Now in these times of cost containment which mandate early discharge or short stays, we must also rely on families for the complex physical care of these children. We know children are being discharged home to families with inadequate community support. We know that the divorce rate increases in these families, likely a reflection

of an overburdened system.

In hospitals such as HSC we can perform miracles in terms of saving lives. Ethical issues, however, often arise in terms of the quality of life of the children and their families who are the product of our technological advances. The importance of psychosocial issues is often lost in our obsession with saving lives at any cost.

Despite being able to identify parents vulnerable to abusing their children and also unable, we feel, to adequately care for their children, we often find ourselves having to hope that things will work out rather than being able to direct parents to the support to ensure that they will. Many of our child welfare agencies feel that they have their hands tied and can only intervene after the fact of established abuse, as opposed to circumstances where abuse is suspected or high-risk factors make abuse predictable even before it occurs.

The CFSA's least-intrusive measures provision is being interpreted too narrowly, from our point of view, so that early intervention to protect children, as was intended in the CFSA, appears not to be truly possible. Grisly stories of our inability to intervene and even monitor high-risk situations without parental consent make us all feel that the law is not working as originally intended.

We have become obsessed with rights—those of parents when dealing with young children, and those of teenagers as individuals—but in so doing we are losing sight of our obligation to protect our most vulnerable, our children of all ages. We have taken for granted the important role that families play in raising our children. Now, at the same time as families become more stressed, our community supports have dwindled. We need to find ways of supporting families, especially those in the most vulnerable situations: families with infants, especially those who have low birth weight and those suffering from a physical illness or developmental disability. Families in poverty or in which parents have been abused generally need more support.

Programs such as the public health nurse visiting programs have been shown to make a difference in terms of providing information and support to new mothers and can act as a way of monitoring at-risk families and refer them to appropriate resources. Unfortunately, some of these public health nurse visiting programs have been cut back with the current cost containment and there's been greater emphasis on providing group care as opposed to public health visiting of individuals. This has eliminated in many communities what we used to have as a way of picking up those families most at risk.

Lay home visitor programs such as Parents Helping Parents in the city of Toronto health department are designed with a similar focus to provide support to new mothers but cost much less. They've also had great difficulty getting support so that they can be generalized more throughout our community.

Discharge planning programs and parent support programs are also making a difference in reducing parents' sense of being overwhelmed and isolated. Again, these are not as widely available across the province as they could be.

Service providers working with high-risk families need education and support to carry out their difficult roles. Community-wide prevention programs are needed to support families and ensure optimum outcomes for children. Treatment, however, must continue to be available to those children and families who most need it.

Those of us working with vulnerable families are greatly aware of how important appropriate support services can be to help raise healthy children. Investing in this end of our health system today will mean many more happy, healthy and productive citizens tomorrow.

The Chair: Now, last but not least—with Mrs Cunningham here, I can't say that London would ever be last.

Mrs Dianne Cunningham (London North): You're right about that.

Ms Lorraine Adam: I'm Lorraine Adam from the Children's Hospital of Western Ontario, Victoria Hospital. I will start our joint presentation and thank you again for the opportunity. I endorse both of the statements that have already occurred. In actual fact, although we've approached our topics somewhat differently and had very little collaboration, I think you'll find some of the same issues presenting in each of the briefs.

Because the children's hospital is a facility where we see a great cross-section of different types of situations in families related to the health concerns of their children, I think the children's hospitals in general are in a very unique position to get that broad perspective. Although we are in the business of health care, we do espouse the philosophy of holistic care and family-focused care, as do the other hospitals, and certainly inject into our work with children as much focus on the families as is possible. Although there are improvements that can be made in that regard, we attempt to address that.

We could have selected just a wide array of groupings of children we see as vulnerable for the social at-risk group I think your committee is interested in. We have chosen four. The main point that we want to make, as well as some specific thoughts on each of these groupings, is the fact that a serious health concern with a child in a family poses a tremendous amount of pressure and strain, adjustments to their lifestyle, adjustments in their financial status, just a number of different strains and stresses by virtue of the health concern alone and the demands that places.

In addition to that, if these families are already in a socially disadvantaged position by virtue of family breakup, single-parent families, financial problems, unemployment, poverty, poor housing, poor nutrition, all of those very broad social problems that I think we read about and see a lot of, it almost makes it a double whammy for these children and families in terms of dealing with the health concern within very strained resources already, because we know that it takes a tremendous amount of strength and coping to deal with sick children, particularly very ill children and children who are ill for a long period of time.

1740

We try to deal with the health part, and there are a lot

of other people who have to be involved in some of these broader social issues, but we certainly see it come right home into the hospital when the two converge with a health problem and the social disadvantage.

I'll stop there and give that over to Ellen, who will highlight some of the issues related to these four groupings, some of which are similar, but there are a few unique aspects. We'll try to hit the high points.

Ms Ellen Rosen: Thank you very much for inviting us to participate in this hearing. My name is Ellen Rosen and I'm going to highlight the issues for groups of at-risk children: children with chronic illnesses, children who have suffered a traumatic brain injury, child victims of sexual abuse and newborns of high-risk parents.

The first group is children with chronic illnesses. This group consists of children with lifelong conditions, usually originating from genetic causes or perhaps from trauma at birth. Included are cystic fibrosis, juvenile diabetes, childhood cancer, cerebral palsy, muscular dystrophy and birth anomalies. Frequently, these conditions require extensive and long-term treatment and repeated hospitalizations over many years.

Obviously, the family is typically overwhelmed at the initial determination of diagnosis and immediately swept into the complexity of the health care system and the hospital, and family life as they once knew it becomes turned inside out.

The demand and emotional strain on parents, as well as siblings, is great. Frequently it's a cyclical thing, with an ebb and flow, sometimes requiring more needs from the hospital and sometimes requiring fewer needs, depending upon the progression of the illness or the disease.

In some cases, the conditions result in a death. Children with cancer really do fit the definition of a child with a chronic illness, and although some may survive for extremely long periods of time and may be cured during the period of their treatment, they are subjected to an endless array of treatments, frequent hospitalizations and endless stress on their parents, their siblings and themselves.

Other practical issues that I believe have been raised by the other presenters are costly medicines, transportation, special care arrangements, appropriate schooling and recreational and social activities, to say nothing about the extraordinary demands on what has now become common, which is two-income families.

We have 80 children with cystic fibrosis followed at our hospital and 400 children with juvenile diabetes, and each year approximately 250 children with cancer are treated. That includes 50 new cases each year, with most being treated for an average of between 18 months to four years.

A recent review of our patient admissions has showed that we have 411 long-stay patients; that is, patients who stay over 30 days. Quite a few of those stay for six months. Recently, we have had two children who stayed in our paediatric intensive care unit for over one year. This group represents 45% of our total patient days.

A subgroup within that population are medically fragile

children, and we have 80 of these children per year.

What are the issues? Emotional strain on families in the care of these children and the impact on family functioning; a need for specialized education for families so that they can manage the medical condition and the developmental needs of the child; a need for early intervention stimulation programs and special education opportunities; financial assistance to help with the cost of care, medication, and transportation to and from the hospital endlessly; a need for respite care for families, so that they can have a break from time to time and pretend to be normal, even for a weekend.

Children are susceptible to additional mental health problems, such as low self-esteem, depression, psychosis and anxiety reactions, depending upon how long they survive. We've already heard about families with pre-existing social difficulties.

What are our recommendations? There need to be some innovative service delivery models which encompass a family-focused approach, bridging the hospital to the home to inject services such as support for families, care assistance, respite care and education needs on a continuous basis. We feel that it could incorporate a lot of current services but needs integration and coordination. Support the development of self-help groups for these groups of families. Explore the feasibility of small family-focused step-down units for medically fragile children in order to bridge the critical care units of hospitals and special foster homes.

Children with a traumatic brain injury are those who suffer severe closed-head injury from accident and/or abuse, cardiac arrest which is resuscitated, sudden infant death and near-drowning survivors or children with encephalitis. These children also pose special problems, should they survive the initial crisis-care episode. We see approximately 55 to 60 of these children every year.

What are the issues? The family impact and continuous strain are similar to those for other chronically ill children; in these situations, though, made worse by the fact that most of these families started with a child who was normal and have to adjust to a child who may be left with residual deficiencies as a result of the insult. Frequently, these children require specialized rehabilitation services well beyond the acute hospital phase of treatment, and many of these services are not available in all parts of the province. Community reintegration into family, school and community pose the greatest challenges for these families, should they get to the point of being able to leave the hospital.

Our recommendations are that there be the development of family support services and the establishment of community rehabilitation outreach teams from tertiary care centres to smaller communities. This would enable training and support to local professionals in addition to direct services to children and families. Of particular importance is the assistance to schools in the management of these children.

The third group are child victims of sexual abuse. These children may be physically damaged as well as emotionally damaged and psychologically damaged for a lifetime. Current estimates from retrospective studies

indicate that one in four girls and one in eight boys are exposed to inappropriate sexual activity, abuse or assault. In London and county, the children's aid society reports that there were 802 cases reported to it and that it investigated in 1992, and 892 in 1993. The London police department investigated 230, an increase of 38 cases over 1992.

What are the issues here? The causal factors, disclosure processes, which we've already heard about from our colleagues, and impact on the children and their families. Frequently these situations occur within these very dysfunctional families, and children experience severe psychological problems which may recur into adulthood. Legal and forensic investigations and verifications are complicated and require substantial expertise on the part of health care and social service professionals. The treatment of the children is difficult and long-term, with varying outcomes.

London urgently requires services for medical and multidisciplinary assessment and treatment for these children and families. A request for such funding is being prepared currently by the Children's Hospital of Western Ontario for the Ministry of Health. Collaborative initiatives are required within communities, hospitals, schools and children's aid societies to deal with this problem.

Innumerable strategies are needed, including the training of professionals in identification of the occurrence, early identification, education and support for parents, pre-parenting awareness and education and adequate services following identification. Again, coordination of a continuum of services is required.

Finally, newborns of high-risk parents: These children are born into families that may be functioning marginally as a result of a variety of social problems. Generally, this is a grey area, as it is difficult to presume negligence if a mother has not yet had an opportunity to parent a newborn due to the fact that the newborn is needing to be hospitalized in a tertiary care centre.

The Victoria Hospital identifies 50 of these children per year out of approximately 3,000 births, and goodness knows how many more from St Joseph's Hospital, the tertiary care neonatal intensive care unit. With the current abbreviated stays for the parents, we are sure that we are missing some of these patients.

1750

The issues are inconsistency in being able to identify the situations; a need to monitor and supervise children adequately in order to prevent harm and neglect, especially where voluntary cooperation of the parents is not possible; and preventive measures.

The recommendations are: innovative services need to be devised to reach and follow these parents beyond the hospital in order to prevent abuse situations. Comprehensive services are needed to break the cycle: to provide support and teaching of the mother, improvement of social conditions for families and early intervention for the children.

In conclusion, the impact of the conditions for groups of children at risk places enormous pressures on families to manage the medical requirements for the child and to

maintain stability in their family life. We feel this substantially affects the child, and often siblings, and for families who are already disadvantaged it places the children doubly at risk. Managing the child's special needs at the best of times requires exceptional skills, strength and resources within a family and its network.

Solutions are not easy. The complexity and magnitude of the issues often overwhelm policymakers and providers, and consequently only incremental change of the status quo continues. As we are faced with resource constraints and the complexity of the issues doubles and triples all the time, the challenges are great.

It may be advisable to look at flagship models in designated communities for coordinated children's services under some mandated framework of key agencies.

Then there are the macro issues to deal with, such as poverty, unemployment, housing, social acceptance, inclusion and education, all of which then still need to be dealt with at another level.

Thank you very much for the opportunity to share our concerns with yourselves.

The Chair: Thank you. Again, there is no way in the time for questions we're going to be able to deal with all of the very thoughtful points that you've made, but we will do our best in the time available.

Mr Hope: I'm curious as to the first presentation and the challenge "Talk the talk, walk the talk." In the 1980s, we found problems in our community. We went out and found funding for that problem, whether it was through Community and Social Services or through the Ministry of Health. Today we're faced with constraints, which was put forward in your presentation, and I'm hearing the word "integration" of services.

I can just see Health and Social Services—Health, which is funded 100%, Social Services, which is funded 80%—sharing resources. I go through that with children's services in my own community. You talk about sharing services. It's like the barricades come up and they prevent each other from participating with one another.

My understanding, and through my conversations, because I've been a strong pusher—I'll tell you, I've faced nothing but resistance from communities that said, "Once this government's gone, our funding will be restored and our financial problems will be over with." I beg to differ with them on that issue, but I'm sitting there and I hear the word "integration" of services. I hear the saying, "The government take action." I don't hear the communities putting out plans. Yes, they're working closer together, but I don't see them—when I look at children's services, for instance, the administrative bodies and all these agencies, the communication level.

It's easy for us to say, "I have a perfect proposal that I could put forward and lay on the table tomorrow." I'll guarantee you that those who are going to be affected by possibly losing jobs and putting more front-line workers into place are going to be right up in arms, turning the political spectrum back on the politicians, "Why are you doing this?" We've seen it with long-term care, and if we try to do it with this—I understand the comment you made, and I agree with it, but I think the people who

have to talk the talk and walk the walk are not just the politicians but those agencies that have had the benefits of the 1980s and now are faced with a structural change to deal with the social-economic issues that are in our communities, the integration and combining of acts so that we can work closer to children.

I get inflamed when I'm being told, "Walk the walk now," or, "Walk the talk or talk the walk, politician, now," but the first time I put an initiative out in the community, it's like major opposition comes from those funding agencies that say, "Don't touch me." I just wanted to respond to the first presentation, because I was sitting here patiently waiting for a chance to ask a question on that one.

The Chair: I sense some trauma here.

Ms Tataryn: I think we could probably all respond with some comments to that. I had the opportunity to hear a little bit about the comments from the earlier presentation related to turf protection and difficulties in working together, so I don't doubt for a moment that those difficulties exist in the community. But I think we do have some models in some of the communities in Ontario. Actually, I think London is a very good example where there have been extraordinary efforts to reduce those barriers, and there are other model flagship programs across the province also.

My experience is that it is a struggle between issues of enhancing service, which still needs to happen. Although there were the booming 1980s and new programs, I think you've heard all three of us speak about a need for enhanced services for high-risk groups and the need to coordinate the services.

In our community, we've attempted to streamline and coordinate some services, and there has been resistance to that. The reason there's been resistance to it, though, has not been from the perspective that we don't need to be better coordinated. It's a reluctance to put funds into administrative, coordinating bodies and a real need to move funds to the direct service level.

I'm not sure that the reluctance is always to protect what one has but I think a concern that in some way if we move towards a coordinating mechanism, what we'll see grow in front of us is yet a new monolithic administrative, coordinative mechanism which will rob the direct services from the community. That's one observation that I might have.

Dr Susan Bradley: I wouldn't mind picking that up, because in one of the recent research reports that's come out from the Better Beginnings project, which is an excellent example of the community being required to bring all its forces together, one of the main recommendations is that the ministries have to still get their act together because they are continuing to do things that interfere with program development at the local level. It cuts both ways.

Ms Adam: I'd certainly agree that it's an extremely difficult task, but I think it is possible. I might be somewhat naïve, but I think it is possible. It's like you need a few leaders within a community as well, perhaps with yourself, for example, in your area. You could start to

develop that connection around communication and try to challenge a few of your agency leaders to work together.

I know we had an interesting experience in London when we were coming together with about 15 agencies around a table to put together a proposal for the quick response for the elderly proposals. We all started kind of holding on to our little bag of resources and not wanting to give too much and not wanting to say exactly what you had and that kind of thing. We realized in the end that we weren't going to get any more money. I shouldn't say that, but London probably is not going to get their proposal approved.

But what we decided to do in principle was to agree to improve our services in spite of no additional funding. I think the relationship and the communication we had in that planning group—we are now continuing to meet and looking at streamlining services and looking at collaborating together. I think the message comes really slow in terms of “You’ve got to work together and partner,” but it is coming. Those things can get quite exciting in terms of the planning of them.

Mr Hope: We could interestingly have a conversation about this, but I notice Mr Beer wants to move on with further questions, because the issue about envelope funding in children's services has been brought up. Human services boards are a key factor in dealing with the socioeconomic issues and the community issues, to be more flexible models.

Ms Adam: I think if you start, though, from people having to give up some of their resources right off the bat, you're probably going to meet with the resistance, but if you can start with people working towards the common goal of their services meshing together for children, I think you're going to get further ahead.

Mr Hope: Do we have enough time? That's the question.

Ms Adam: Probably not, but I guess you've got to start where you're at.

1800

Mrs O'Neill: I'd like to thank each of you for coming. I know a little bit about each of your hospitals. I know for sure that each of the communities that you are located in values you as one of their best resources. You have very special spots not only in their heads but in their hearts, and I feel that those have been gained through experience.

I'm going to go to Ms Tataryn because that's my community, and I have to make a choice. The McHugh school that you've brought forward, I'm very pleased that you chose that as an example and I think you've described it very well here. I wonder if you could bring us up to date on just where you see that at the moment. Is there a future for the school? Every year about this time, I start to get letters from worried parents about that facility and I just wonder if you could tell us how you see it at the present time.

Ms Tataryn: I'm pleased that you've asked that question because I can speak further to Mr Hope's question about coordination.

The issue around schooling for children who have

severe emotional issues touches on the health, social service and educational sector, and it is traditionally an arena in which the ball has been bounced back and forth between those sectors.

My earlier comments related to each institution reviewing mission statements and becoming more narrowly focused, and there is no doubt that for some of the section 27 schooling programs for emotionally disturbed youngsters, when CHEO and other hospitals have reviewed those programs, they have not perhaps ranked as highly as some of the programs that we've heard described here in terms of the traditional medical needs of head injuries and chronic and terminal illnesses.

What has been put together in Ottawa-Carleton is, I think, quite a heroic effort between Health, Community and Social Services and the Ministry of Education, with funding from all three ministries to develop a community plan for the McHugh program. At this point, June 1994, we're halfway done in the development of a plan for Ottawa-Carleton for all of the McHugh programs. It has not come through any turf protection; it has come through all those ministries sitting down and meeting, literally, weekly, deciding what's Health, what's Community and Social Services, what's Education, keeping in mind that the bottom line is the numbers of kids in our community who continue to require the service, wherever it's delivered and however.

I feel very optimistic about that as one example. It came through a crisis, though, I will tell you. It came because parents protested so loudly and said, “You three sectors must work together, because we cannot bear this burden ourselves as parents; nor can the school system.” So I feel optimistic that we will have a plan in our community for that McHugh program that will be truly collaborative.

Mrs O'Neill: Thank you very much. I'm very happy to hear that.

Mrs Cunningham: I just think we're so lucky in Ontario. You represent three of, I think, the more important hospitals in the world. People are usually looking to us for leadership, and one of our great strengths is that we're always looking for doing things in a better way. But given the demands in society and how things have increased in the last 10 years, it's just getting ahead of even the best of everybody.

I have two or three questions, and whoever answers would be fine. I did get the message that we'd better look into the funding for Victoria Hospital: “Children's Hospital of Western Ontario for the Ministry of Health.” I noted that one on page 6, so we can talk about it.

But before I start, the different ministries do get in people's way. We spend so much time—and this is for my colleague and friend Randy Hope—asking people to put together grant proposals. It we had that kind of energy and we could put that into the front lines with individual families—and I know you share my concern and you've seen it as a member of the government. That's one of my greatest beefs.

My other one stems from my work at Merrymount Children's Centre in London where I, in my professional

life, would have dealt for some seven years, along with one of my great colleagues who's worked with both of you, Jan Lubell, where we saw these parents just being pushed from pillar to post. I mean, they had no idea and they couldn't get their cheque or they couldn't get their money or they couldn't get help unless they went to the doctor and the school and the Madame Vanier. There have to be models. So I was happy to listen to Dr Bradley mention that there are models that are working, and we should be building on those that are working.

I don't know where to start. I also heard Dr Bradley talk about the ministry for children, and we're seriously looking at that. But if it's more people talking and not more front-line services, we've got a problem.

There's great turf protection in London. When we get into something—and maybe you have too in your community, Mr Chairman—where somebody has to give us funding, even for things we've already got the money for, to allow us to spend the money, like at Victoria and St Joseph's, it's been a year of everybody's time. Perhaps you see it as well, Yvonne. So much is going into pleasing the bureaucrats and getting through the system, and there's so much red tape. I don't know if one more ministry would be helpful. Maybe if you say there's going to be another ministry but only a third of the people who are working right now can work in the ministry, or 10%, and everybody else has to get out and do what they were trained to do, it would be very helpful. I don't know.

You've heard my concerns. How do we make it simple for parents? They have to work with their children who are at risk. I am one of those parents, I have a child who's at risk, and if I had done all the things I was asked to do, I'd have to go 24 hours a day; there would be no time for sleep. I had to make a choice.

Ms Rosen: To address just part of that, one of the things we have had as part of our commitment has been to look at some of the high-risk groups and say that probably these people need a person to help steer them through the system, and we've allocated resources for what could be called case managers—in most instances they are nurses—people whose job it is to help finesse the way; not necessarily taking over totally from the family, because to a degree there's a certain amount of independence that should become a part of the recovery process for families as well, but just paving the way, even for referral back into hospital.

But it is very difficult, when pushed to the wall, to show—one is not allowed to randomize the groups within each subset and say: "This part of the room is going to get this nurse looking after them, and this part isn't. We're going to follow these families for the next 10 years and see what effect it has." Because that would really be the only way you could substantiate that having the person there was better than not, it becomes very difficult to substantiate.

As we get more and more pressured and as the technology is available, thank goodness, because of medical advances, we are going to be faced with more and more at-risk populations that we'll have to put front-line care givers to because that's where it makes a difference for

people, and I'm not sure where we're going to pull them from. It's a never-ending dilemma, but that's part of our dilemma in terms of care delivery, and then on top of that we have to spend time arguing or debating or figuring out how to move through the ministries and the turf.

Mrs Cunningham: Do you think the demographics of our society may be helpful? There are a lot of people who are retiring early and still have a lot to offer, and they could be doing volunteer work. Many of them come into my office who would be willing to work and retire even earlier than they are already. Heaven help us, some of our best people are choosing to go because of the stress. But they'd be happy to come in for two or three part-days and work for nothing or be volunteers. I think there could be more energy put into that area of helping, especially when we've got children. So many people are interested in helping children, but I'm looking at some people who know a lot about volunteers. Is it worth pursuing, or what can we say there?

Ms Adam: We're always more than happy to look at using volunteers, and we have an awful lot of them. Where we find a little difficulty is having the time to come up with some innovative programming so you can use them effectively.

I would just like to go back to the one point about this business of, how do you start and where do you get at it? Because the structures are so massive and there's so much overlap, with pieces of information here, there and everywhere and not everybody knows the total workings of all the departments and the services, my own training tells me that you start in some small place and start to develop there; maybe you start a few small pilot things here and there. But get the people who are in service provision together and start to figure out what it is we would change, like: If we had the miracle happening overnight, what would it look like tomorrow, and how do we start getting that in our local area? Maybe that then starts to change the policy and the structures and the bureaucracies, because if you start from the other end, I honestly think we're immobilized.

1810

Mrs Cunningham: I have to agree with you, because when I worked for one of the ministries it was one of the worst experiences of my life because of the red tape and not being allowed to get the work done. It was truly the worst position I've ever had in my whole life, working for a government ministry. It was a fairly high-profile job, which I've shared again with my colleague who keeps smiling at me. It was so frustrating, because the front-line people did come up with the models that would work and were prepared to do them and in fact it didn't take more money, but somebody in some powerful position just decided it wasn't worth putting it forward. I lived like that for a couple of years of my life and just had to leave. You can be assured that if anybody wants my expertise down the road, if we're fortunate enough to get into government, I would have no patience for people like that.

I think you're right. Starting all over and just saying—and it may vary from community to community, given

the resources, am I correct? There's the way you might do it in your community, and listening to Yvonne talk about a school that obviously is very successful, and Randy talk about his frustration, all of us have strengths in our communities that we should be building on. It goes back to using the models that are working and building on them.

Ms Adam: Each community has its own demographics as well in terms of the types of groupings.

Ms Tataryn: I think one example is long-term care, where there have been tremendous gains made in the area of what we might call one-stop shopping or multiservice agencies. There are models now close to being implemented, as I would understand it. What that guarantees for families is at least a place to enter the system, a place to know where to call.

An anecdotal comment about our hospital is that when people call looking for services in the area of sexual abuse treatment, once you say, "I'm sorry, we don't have any services to offer you" or "We have a long waiting list," and a parent says, "Where could I call?" or "What could I do?" or "Could you help me?" you almost de facto become their case manager and you then begin the process of trying to find services for them, to service-broker for them. There's a reluctance to do that because of the dearth of services, so people are frantically looking for the proper place to call. They have their names on waiting lists in every different program in every different part of the community because they don't know where to call.

I guess my response is a hopeful one. There have been models developed in problematic areas of care such as long-term care that could be moved over, transferred over, superimposed on an area of children and youth, with similar guiding principles that were elaborated in the Children First document: ease of accessibility, services to the hardest to serve etc.

Mrs Cunningham: I would agree with you that there have been some gains made in that regard, if other things didn't get in the way. I think the individual who is getting the service has to have some choice, and one of the great concerns we have in London is that that's not the case. People who have home care providers right now are told they can no longer use them because they happen to be working in a private sector agency. That's wrong, but we have governments from time—I don't mean to be political, but that is a big mistake. The best service provider is the one who has to provide it.

That's the kind of red tape and stuff that gets in the way of having people be excited about their work. Right

now they're very depressed and frustrated. I would agree with you, but I had to throw that in because I think it's an example of the kinds of things that stop progress for a long time. It's just one of those things that's happened.

The Chair: I'm going to have to jump in. If you would like a final response on any of that, please go ahead, but we are going to have to close.

Ms Rosen: I'll keep it short. I was just going to echo your comments. The long-term care reform in principle is a good model, but the complexity—what we find is that to broker the services we need to enable these medically fragile children to go home often requires us to subcontract to a number of agencies, all of which have very unique expertises, and that's throughout southwestern Ontario. If we had to negotiate our way through a morass of bureaucracy to do that, it would become a nightmare and it would be far easier to keep the children in hospital. I would plead that any model that is developed has got to be an enhancement of the principles that are inherent in the one that has just been tabled.

The Chair: Probably the experience of all of us here, the longer one is at Queen's Park, and certainly my own experience as minister, is that you have to find something at the community level to solve a lot of this. You clearly need support and you need the ministries that work together, but somehow it seems that if you try to run everything from Queen's Park, it inevitably fails. The critical tension is to find the direction and the funding but then the flexibility at that local level to do the kinds of things you've been talking about.

Our discussion today has been very helpful. As we go through this, we've heard a number of interesting ideas and some themes that are starting to emerge. On behalf of the committee, I thank you all for coming here today. You've left us a lot of material, and we appreciate that.

With that, committee members, I note that we will be returning to this subject next Tuesday, June 7, but we will reconvene on Monday at 3:30 to deal with Mr Ramsay's bill, which we will deal with on that one day.

Mrs O'Neill: May I ask when we'll get the draft?

The Chair: There will be a subcommittee meeting, Mrs O'Neill. We have a number of issues we are going to have to discuss.

Mrs O'Neill: Will that subcommittee meeting be before next Monday?

The Chair: We'll work that out shortly.

With that, the committee stands adjourned until 3:30 next Monday.

The committee adjourned at 1817.

CONTENTS

Tuesday 31 May 1994

Children at risk	S-1543
Ontario Association of Children's Aid Societies	S-1543
Mary McConville, executive director	
Bill Charron, executive director, Niagara Family and Children's Services	
Roy Walsh, executive director, Brant Children's Aid Society	
Jerry Muldoon, executive director, Renfrew Family and Children's Services	
Bruce Rivers, executive director, Children's Aid Society of Metropolitan Toronto	
Youth in Care Connections Across Ontario	S-1553
T.J. Whitley, youth liaison worker	
Kim Way, youth program worker	
Susan Bradley; Karen Tataryn; Lorraine Adam; Ellen Rosen	S-1558

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- ***Chair / Président:** Beer, Charles (York-Mackenzie L)
- ***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- *Carter, Jenny (Peterborough ND)
- *Cunningham, Dianne (London North/-Nord PC)
- *Hope, Randy R. (Chatham-Kent ND)
- *Martin, Tony (Sault Ste Marie ND)
- McGuinty, Dalton (Ottawa South/-Sud L)
- *O'Connor, Larry (Durham-York ND)
- *O'Neill, Yvonne (Ottawa-Rideau L)
- *Owens, Stephen (Scarborough Centre ND)
- Rizzo, Tony (Oakwood ND)
- Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Gardner, Dr Bob, assistant director, Legislative Research Service



S-55

S-55

ISSN 1180-3274

**Legislative Assembly
of Ontario**

Third Session, 35th Parliament

**Assemblée législative
de l'Ontario**

Troisième session, 35^e législature

**Official Report
of Debates
(Hansard)**

Monday 6 June 1994

**Journal
des débats
(Hansard)**

Lundi 6 juin 1994

**Standing committee on
social development**



**Comité permanent des
affaires sociales**

**Chronic Care Patients'
Television Act, 1993**

**Loi de 1993 sur l'installation
de téléviseurs appartenant
à des malades chroniques**

Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENT

Monday 6 June 1994

COMITÉ PERMANENT DES
AFFAIRES SOCIALES

Lundi 6 juin 1994

The committee met at 1556 in room 151.

CHRONIC CARE PATIENTS'
TELEVISION ACT, 1993LOI DE 1993
SUR L'INSTALLATION DE TÉLÉVISEURS
APPARTENANT À DES MALADES CHRONIQUES

Consideration of Bill 18, An Act to permit Patients receiving Chronic Care to install their own Television or combined Television and Video-Cassette Recorder / Loi permettant aux malades chroniques d'installer leur propre téléviseur ou leur propre combiné téléviseur-magnétoscope à vidéo-cassette.

The Vice-Chair (Mr Ron Eddy): Good afternoon, ladies and gentlemen. Welcome to the standing committee on social development, discussing Bill 18.

The first order is opening statements. Mr Ramsay, do you wish to speak to the matter?

Mr David Ramsay (Timiskaming): Mr Chair, I would like to reserve my opening remarks until after the presentation that's going to be made next.

Mr Larry O'Connor (Durham-York): Mr Chair, I would like to hear some of what we're going to have presented to us; to hear some of the concerns that the Ontario Hospital Association may have with this bill, and I look forward to an open dialogue.

LAWRENCE SAMPSON
THOMAS SAMPSON

The Vice-Chair: The first presentation will be made by Mr Thomas Sampson and Mr Lawrence Sampson of Kirkland Lake. Introduce yourselves and proceed with your presentation.

Mr Lawrence Sampson: I'm Lawrence Sampson. Introduce yourself, Dad.

Mr Thomas Sampson: I'm Tom.

Mr Lawrence Sampson: My father has asked that I read this and give you a brief presentation and then, should you have any questions afterwards, my father or myself will be glad to answer them.

Good afternoon, ladies and gentlemen of the standing committee on social development. It's with much regret that I find myself seated here, taking up the government's time and energy in order to have a law passed so my wife Eleanor can be allowed her own television, with VCR, in the Kirkland and District Hospital.

Eleanor has been a chronic-care patient in the hospital for approximately three years and is totally bedridden. Her only forms of entertainment are reading and watching television. Both have become much more difficult due to

her failing eyesight. This is partly because she is a diabetic and also due to the fact that she has had some ministrokes.

I would like to present you with a copy of the original letter sent to the hospital board of directors, from myself, requesting the option of Eleanor using her own television. You'll find that in the folders. The letter was addressed to Mrs A. Mangotich, and in that we are asking, basically, for my mother to be allowed the use of her own television. We had hoped to buy her one for Christmas and have it installed. This was denied.

I would also like to present you with another letter, giving the history of the steps taken in order to attain a favourable outcome to this reasonable request. Unfortunately, since November 1991, no successful conclusion has evolved. This is a letter that eventually ended up getting to Mr Dave Ramsay. It is addressed "To Whom It May Concern." In it, we go over the steps of what we have tried in order to get my mother a television. We tried to go through all the proper channels and do things in the right manner, going through the hospital board and the whole bit; to no avail. The hospital itself we were just unable to deal with.

We went to Sterivision themselves, asking them, could they consider even getting my mother a larger television? Sterivision was willing to do that, but the hospital itself said: "No, we don't want to set a precedent. You cannot have a larger television for your mother." We were, at that time, prepared to pay whatever the full rate may have been for that, which was, at that time, \$82 a month, and it still is. We had called on Mr Webber regarding this with Sterivision.

On the monetary aspect, the present fee for television costs \$82 a month. That's \$960 per annum. You can buy a good 14-inch colour television for about \$400. Your basic television channels are about \$152.68 per annum. If you take that \$450 and the \$152, that only adds up to \$600 per year, and you have your own television. Now, mind you, on top of that no doubt there will be some fee that will have to be paid to the hospital for electricity or whatever. I'm perfectly willing to go along with whatever charges there might be. We're also perfectly willing to supply whatever CSA-approved television might be needed, whether it be no less than a three-year-old or a two-year-old or one being replaced every three years, whatever the hospital would dictate, within reason. We could follow that.

It's been cited by the hospital authorities that safety is a major factor in the denial of this request. My question is just how important the safety factor is when at least

two personal TVs have been in constant use in the present hospital since it was built about 15 years ago. The use of commercial rug cleaners in hospital rooms is a common occurrence and most certainly would draw much more power than any television or VCR. They actually use the same electrical outlets.

You'll see CSA leakage requirements. Unfortunately, I can't give you a lot of detail on this because it's just way over my head. So you may have to phone this gentleman concerned. There is a number you can reach Richard Fraser at and he can tell you a little bit more about these hospital leakage requirements. But, basically, from what I understand, this says there's no big deal. Okay?

Forgive me; I'm a bit nervous.

Mr Thomas Sampson: Take it easy.

Mr Lawrence Sampson: I'd also like to present the committee with a breakdown of present TV channels available to all cable-subscribing households in Kirkland Lake and those available at the Kirkland and District Hospital through Sterivision. You'll find in your folders that there are photocopies similar to this. In the yellow you have channels roughly from 2 to 41—this whole batch here—which are all basic channels which are available to individuals in their homes. The yellow indicates the ones that are only available through Sterivision. Of these yellow, approximately three are French channels—my mother does not speak French—two are the parliamentary channels and two are local channels, one of which is a local television station giving advertising and the other having the local radio station on it. These channels at the bottom end are not available at all through Sterivision. Pay TV is not available through Sterivision as well, because the electrical hookups are not compatible with the black boxes that are provided by the cable outfit.

Also, you have some pictures of a personal television in my wife's room, showing how the wiring is handled, and also a picture of her TV, how the wiring is handled in hers. I refer you to this one here. You can see that the wiring has just been taped together and it's just running along the edge of the wall into a plug over here, from which the cable comes and your wiring is basically in the same spot for electricity. It comes through the television; it's tucked away towards the wall and really doesn't present that much of a tripping hazard.

This is a picture of the same television from a different angle; and these as well. They're all just showing how the cords are set up. Like I say, they don't seem to be presenting a tripping hazard, because the nurses have been working around them for years.

This latter picture is one of my mother's television, hanging from the wall, the Sterivision one. You'll notice considerable difference in the size of the screen. This is an eight-inch screen on my mother's television, whereas this is a 12-inch screen on this one here. The size of the television makes a considerable difference for somebody who can't see well.

I hope the information that I've provided will help you to seriously consider sending this bill on to the House for third reading and subsequently become law. It seems

very, very sad that people have to go this far in order to have their human rights properly taken care of. Thank you for allowing me to speak on this matter.

The Vice-Chair: Thank you. Did your father wish to add anything at this time? Then we'll go to questions.

Mr Thomas Sampson: No, just that my wife has been a faithful wife and a mother over 56 years and that I figure I owe her this, to fight on her behalf, because she can't do it herself.

The Vice-Chair: Questions, Mr Ramsay?

Mr Ramsay: First of all, I'd like to thank very much the Sampsons for coming down today. It was about two years ago that Thomas Sampson came to my office to talk about this problem in, I believe, about the spring of the year. What started it was that Mr Sampson wanted to give his wife a VCR so that she could watch something other than regular programming on the television set that is supplied by the hospital at \$82 a month.

Lawrence has started to talk about some of the technical problems with that, but as you know, many hospitals have contracts with various companies, though a lot of them tend to be this one, Sterivision, in Ontario, to supply at a rental fee that is negotiated between the hospital and the supplying company. As Lawrence has pointed out, these sets, particularly the ones in Kirkland Lake, are old technology that only bring in about 13 channels, not even the full basic service, let alone have the ability to provide any other, additional service if the patient wishes to purchase those. As has been pointed out, the set is incompatible with hookup to a VCR.

So what we have is a frail, sick, elderly person in a chronic situation in our hospital in Kirkland Lake. For many in a chronic ward this is their home, and for many of those in chronic wards it may be their last home. What we're seeing is that, through a lack of consistency in hospital policy across the province—and I want to talk about that in a minute—many of these people are denied a very basic sort of, I guess we wouldn't even call it a privilege any more but a right to have access for standard television signals.

1610

As Lawrence has pointed out, this is just about all the entertainment that Mrs Sampson is able to get out of life because she is incapable of getting down to the TV room that the hospital supplies for people. It is a larger set. She basically is bedridden. She only has this option.

Ironically, as has been pointed out by Lawrence, there are a couple of individually owned TV sets in the Kirkland Lake hospital that were there already at the time the contract between Sterivision and the Kirkland Lake hospital came into effect, and they're still there.

But what's interesting, when I did a survey a year ago with some of the chronic care hospitals in Ontario and a sample of some of the other hospitals in Ontario, there are many hospitals that have this policy. It seems at least 50% of the chronic care hospitals have such a policy in Ontario and a smaller percentage of hospitals in Ontario in their chronic care wards have this policy.

I want to point out that I'm only dealing with chronic care wards in hospitals and in chronic care hospitals. I

think that if one's in an acute care section of a hospital having some surgery and has to be in there for a few days, one can certainly pay a hefty price for the privilege of watching TV for a couple of days. But when you find yourself in a chronic care setting and this is your home, to be stuck with a bill of \$82 a month to rent a TV set with a seven- or eight-inch screen that limits you to about 12 or 13 channels doesn't seem right to me.

I believe there should be an option there for the patient or the patient's family to supply proper, safe electronic equipment that can provide the basic entertainment that all of us would take for granted out in the world outside of the hospital. Really that's what this is about: having some access to some of that entertainment that we all take for granted out there. I really think that's important.

This isn't the very biggest issue in the world, but it's an issue that deals with people having some equity, people who find themselves in an institutional setting trying to make this a little more like home. I know there are varying degrees of policies with hospitals across the province of: How much of a home setting do you make a chronic care room in a hospital? How many personal possessions do you allow? Can the person have their own phone line? Can they purchase their own cable and the patient or the patient's family pay for that cable? Can you have your own equipment?

One of the reasons—that Mr Sampson hadn't pointed out—is that many of the folks in chronic care hospitals have family. As you know, many hospitals have a policy whereby children are not allowed to come into the hospital room. Having access to a VCR would mean that the family can video-record birthday parties and other events of the family and these tapes can be brought into the hospital and so the elderly patient can, through electronic means, start to partake and share in some of the family activities that are going on in the other home, the permanent home that's back in town. It's this sort of equity in trying to get people back to having a normal life as much as they can in an institutional setting that I'm really talking about here.

Before I was in this job, on a volunteer basis I was the chair of a hospital in New Liskeard: Temiskaming Hospital. As a politician, I particularly don't care to have Queen's Park dictating policy holus-bolus across the province. I understand the idea of trusteeship in a hospital, that we as local people in our towns get to run our hospitals. But when I see such a difference in the quality of policies when it comes to lifestyle issues such as this, I think it's important; it's important that people have the ability and the right to bring in their own television set or combination television set-VCR.

I'd like to thank the committee's indulgence for hearing me out and again thank the Sampsons for coming down.

The Vice-Chair: Thank you, Mr Ramsay. That's under the heading of opening statements, I take it.

Mr O'Connor: That's what I thought too.

The Vice-Chair: Mr Ramsay had requested that previously. We'll proceed to Mr Wilson.

Mr Jim Wilson (Simcoe West): I too want to thank

the Sampsons for coming to Queen's Park and commend you for your persistence. I see one of the letters we have goes back to 1992. How long have you been dealing with this issue?

Mr Lawrence Sampson: A little over two years.

Mr Thomas Sampson: November 1991, actually.

Mr Lawrence Sampson: That we've been trying to get this.

Mr Jim Wilson: It's not the most usual thing that some members of the public would actually stick to an issue so much so as to have it come before a parliamentary committee. I commend you for that and I commend Mr Ramsay for the bill and for this set of hearings.

The bill is very short and quite general. The only limitation on TV sets will be that the sets must be CSA approved, and there's half a sentence here about they must meet other safety standards that may be set, locally I gather, although I'll have to ask counsel exactly what the implication of the phrase is.

Just after our opening statements, a little later this afternoon, the Ontario Hospital Association in its brief—having just scanned through it—is going to bring forward some concerns: Should there be other limitations on the size of the television or, for example, that TVs can interfere with the workers in the hospital and their ability to carry out their functions. If somebody brought in a large, 30-inch TV—

Mr Lawrence Sampson: Yes, there's no question about that. You can't expect people to try to work around a 30-inch television. That's quite unreasonable. We're talking reasonable here. A 14-inch television, in my estimation, is not unreasonable.

Mr Jim Wilson: So should we limit the size of TVs?

Mr Lawrence Sampson: Yes. I say 14-inch is reasonable.

Mr Jim Wilson: I don't know if you can answer this or maybe Mr Ramsay: It's \$82 a month that you're currently paying, that the family's paying, which is a user fee in our health care system, I guess. It's like parking at hospitals and other ways of generating revenue and that's something I will ask the hospital association, because hospitals, through these fees, I think are averaging 18% or 20% of hospital revenues now coming in through various fees, TVs being I think a very small part of the revenue base, mind you. Would there not still be a fee for basic cable service? Would not the family still pay that?

Mr Lawrence Sampson: Didn't I stipulate that?

Mr Jim Wilson: I'm sorry, I missed the first part of your presentation.

Mr Lawrence Sampson: The basic cable fee at any normal household in Kirkland Lake is \$17 per month or \$204 per year if you pay on a monthly basis, or \$152.68 if you pay on a yearly basis. If you pay ahead, you get a discount. It would be expected to pay that. Now, whether that signal is brought through by Fred Lang Television and sold to the hospital and the hospital sold it to the patient, it's up to the hospital how it handles that or if Fred Lang brings it in and we pay Fred Lang individually, so be it. I see no problem with that.

Mr Jim Wilson: I apologize again for missing the first part of your presentation. You may have already explained this, but I have to ask the question anyway. In the over two years you've been dealing with this issue, you've been through the system from top to bottom, I guess, or bottom to top, you've been before the hospital board itself, and they turned you down?

Mr Lawrence Sampson: Yes.

Mr Jim Wilson: Can you explain that and briefly give me the reasons again why they turned you down?

Mr Lawrence Sampson: Their reasons were that they did not want to set a precedent of having a person have their own individual television there because the two televisions that are presently in the Kirkland Lake and District Hospital that are personally owned are by people who were there for some 15 years, since the hospital was changed from the old hospital and a new hospital was built. They were moved there, the two televisions, under what they call a grandfather clause. They cited a safety factor like cords and grounding leakage and all this other nonsense. All we wanted to do was get a bigger television so my mother could see it, period. They just stonewalled us. They would not talk to us. It was just a flat-out: "No. I'm sorry, that's the way it's going to be. If you don't like it, too bad."

1620

Mr Tony Martin (Sault Ste Marie): I also want to say how impressed I am with your persistence in this. I think it's certainly an issue worth chasing. Being from northern Ontario myself, I realize that television is sometimes, particularly for older people, a source of entertainment and education and different things, regardless of how old you are. Certainly I would think, given that you're placed in a facility where you're going to stay for a long time, there should be some accommodation possible re some of the issues you raise here.

You talked about setting a precedent. How many other chronic patients are in the hospital?

Mr Lawrence Sampson: Actually, we really don't have that information. There are two televisions we know of that are used by chronic care patients in Kirkland and District Hospital that are their own personal televisions. That much we do know.

Mr Martin: So there are two people in the hospital who have their own televisions?

Mr Lawrence Sampson: Yes. You have a picture of one of them there.

Mr Martin: So there is a precedent.

Mr Lawrence Sampson: Yes, in my mother's room, the same room my mother is in right now.

Mr Martin: Why are we here when they're already making accommodation of that sort? Why couldn't this have been resolved at that level? I don't understand that.

Mr Ramsay: The agreement that the hospitals enter into gives the company exclusivity to supply televisions in the hospitals. Because these patients were established with their sets before this contract was signed with Kirkland and District Hospital, they were grandfathered. That's why those sets are there today. They were partly

refusing to allow Mrs Sampson to have a TV set because of the contractual obligation to Sterivision.

Mr Martin: Do you know how many other chronic care patients there are in the hospital, Dave, who would be requiring this kind of—

Mr Ramsay: I don't have the exact figure, so I'd rather not say. I'm not sure how many beds there are.

Mr Martin: Is it significant?

Mr Ramsay: Yes, it would be significant; 50 or 60 people in chronic care in Kirkland Lake.

Mr Martin: When you compare that to the whole hospital, what percentage of the hospital would that be?

Mr Ramsay: It might be about 45%. Unfortunately, it's got a very high population of chronic patients in Kirkland and District Hospital.

Mr O'Connor: Mr Ramsay might be able to help me. In the process they went through, did this go to the local hospital board? As you mentioned, hospital boards quite often could deal with individual patient circumstances. Did this go there?

Mr Ramsay: Yes, it did. It was out of frustration in dealing with the local board that the Sampsons eventually came to my office.

ONTARIO HOSPITAL ASSOCIATION

The Vice-Chair: We will proceed now to the next presentation to be made by the Ontario Hospital Association. Please proceed with your presentation when you're ready, giving your names for Hansard please.

Mr Brian O'Riordan: I'd just like to introduce the delegation, first of all. On my right is Dan Drown of the Ontario Hospital Association. Dan is a senior consultant in our chronic care mental health and rehabilitation division. On my left is Jim Armstrong. Jim is vice-president of operations at the Queen Elizabeth Hospital, a hospital that has been particularly monitoring this situation.

I'd also like to indicate that the OHA usually would have a presentation by our senior officers, but unfortunately this is one of those weeks where almost all of them are otherwise engaged in terms of there is a conference in Halifax of the Canadian Hospital Association, so Mr Timbrell and others send their apologies.

My name is Brian O'Riordan and I'm the director of government relations for the OHA. I believe the committee has been provided with copies of our presentation and I will be going through that. Just one other housekeeping bit of business, if I could. I'm not sure how much time we have. Myself, personally, I will be under a little bit of time pressure as we approach 5 o'clock, but my colleagues certainly can stay past that if need be.

As we appear before you today, we know that this bill enjoys considerable all-party support. We've read the Hansard on second reading. We're also aware that various groups for seniors and chronic care patients have lent their support to the bill.

The bill is summarized in the formal legislative explanatory note as giving "chronic care patients the right to install their own television or combined television and videocassette recorder in their rooms rather than having to rent the use of such equipment or to leave their rooms

to watch television in a common area." This right is to be restricted only by the "relevant Canadian Safety Association standards"—we assume this is meant to say the "Canadian Standards Association"—"or any safety standards established by the authority responsible for the place where the person is receiving care," on the face of it, a perfectly reasonable right to enshrine in a legislative regulatory way, with appropriate restrictions on the absolute right to enjoy one's own TV or VCR.

However, when the member for Timiskaming, the sponsor of this private member's bill, first approached us about the concerns which he is attempting to address in this bill, he had already decided to introduce a bill as his chosen vehicle for dealing with the issue. That is certainly his right. He wrote to us on May 4 and the bill was introduced on May 17.

The member and his staff I would like to give credit to, because they clearly worked very hard on this issue. They clearly were doing the work of an MPP in terms of trying to address a difficult problem that one of their constituents was having. They surveyed hospitals, they generated press releases and they garnered favourable local media attention.

All of this activity is good politics but it does not necessarily add up to good public policymaking. For our part, Mr Drown and myself met with the member and his staff last June to review the issues involved. At that point, we had hoped to try to resolve some of our concerns through membership education activities and the publication of existing policy approaches.

Indeed, we have made our membership aware of Bill 18, and I think we have characterized its background and intent to them quite fairly.

I have to report, though, that many members, regardless of whether they currently allow personal television sets in patient rooms, strongly question the need for such regulation and legislative prescription. The hospital sector is already a very heavily regulated sector, subject to dozens of hospital-specific pieces of legislation and regulation as well as dozens of other labour relations, environmental and health and safety laws.

Recently, we have seen the imposition of the Social Contract Act, a massive intervention in free collective bargaining, the Consent to Treatment Act and now further long-term care policies and legislation. Hospitals are also on a day-to-day basis becoming increasingly subject to interventionist actions by the Ministry of Health and local district health councils.

You might appreciate, then, the informal reaction of some of our member institutions went along these lines: "What? Don't they even trust us to administer our TV policies?"

This is not in any way to belittle Mr Ramsay's efforts or to dismiss Mrs Sampson's complaints.

There are aspects of aging and the diminishment of capacities that challenge an individual's reserves of courage and ability to cope, and it is the responsibility of each one of us, especially those in the caring profession, to ease the burdens of illness and give comfort and security in whatever way possible to chronic care

patients. Bill 18 reflects that desire, to give people in difficult circumstances a chance to make some small decisions for themselves that can make their days more pleasant and comfortable. We appreciate that. Personalizing one's institutionally based environment no doubt means a lot to certain patients in long-term care facilities. Hospitals recognize this, and at the same time they are very mindful of the needs of all patients in a given room, floor, department or wing and of the tremendous workload pressures on front-line staff, especially nurses and orderlies.

However commendable the intent of the bill, there are real problems of principle and implementation which we hope the committee will seriously consider.

1630

First of all, many hospitals, especially those that provide chronic care, do allow patients the option of bringing in their own televisions. Logically, it would seem to follow that if some do, then they all should. This would indeed be the case if all facilities were identical. However, the hospitals that make allowances for this aspect of patient choice do so on the basis of their assessment of the particular circumstances of their facility, and circumstances do differ.

There are some hospitals that take a more flexible approach and deal with requests from patients and families on a case-by-case basis. Some hospitals prohibit the use of personal televisions as a matter of general policy but make exceptions where they feel it would be in the best interests of the patient concerned.

Bill 18 proposes that the only grounds for the curtailment of a right to instal a personal television in an institutional setting would be on the basis of safety standards—CSA-related or those set out by an institution—which presumably could be all-encompassing. Indeed, if this is not the all-encompassing intent, then the bill, we would submit, is even more seriously flawed.

This is because of the current situations which obtain with respect to television use in certain hospital settings.

In most hospitals now, the system of delivery of television services is customized to the hospital setting. Televisions equipped with earphones are suspended in brackets from the wall or ceiling to keep them out of the way of the free passage of patients and staff in a room. The televisions are compact, to be sure, and for some people hard to see, but this is out of physical necessity, not insensitivity. In a room with four patients, the small screen may be the only practical size if all four patients want televisions. Some hospitals are aware of the screen size problem already or are in the process of switching over to 14-inch sets, again attached to an overhead mount, and again customized.

The question arises in individual institutions as to how televisions from a variety of outside suppliers could conform to and be compatible with a given standardized system already in place. The presence of any oversized extra furniture in a hospital room can also be an impediment to other patients whose comfort and safety must also be taken into consideration.

Hospitals do charge patients on a rental basis for these

customized television services. Although these rental costs have been characterized by supporters of the bill as being exorbitant or as money-making vehicles for hospitals, it's our understanding that generally the rental costs represent no more than cost recovery on a considerable initial capital outlay in terms of cable systems, special wall mounts and swing-arm units, ongoing request processing, maintenance, repair, adjustment and replacement of sets, and invoicing.

Such systems have been established for the benefit not of hospital administrators but for the direct convenience of patients and the staff who care for them. Such systems standardize the interactions of all involved. This is why they are so popular and are pervasive within the hospital system.

Certain hospitals do allow some of their longer-term patients to being in their own personal television sets, usually with the following provisions: agreement of affected fellow patients; agreement of front-line staff who may on an ad hoc basis be pressed into adjusting, repairing or controlling the use of the television; agreement by the patient or patient's family to absorb all costs of installation, maintenance and removal of set; compliance with local hospital, CSA and other health and safety standards; and patient's willingness to assume liability in case of a workplace or other injury involving the set.

Some hospitals used to allow patients the right to bring in personal televisions but have discontinued such policies for a variety of reasons: staff complaints that patients wanted staff to move sets, adjust them, make minor repairs; posing safety or comfort threats to other patients or staff; sets being used deliberately to injure or obstruct staff or annoy patient neighbours; and continuing disputes among patients over volume control, damage to sets, placement of sets etc.

In a system with over 200 institutions, hospitals and their patients have experienced a wide variety of situations and have come up with solutions that they believe make sense in their local circumstances and experiences. In our experience, hospitals do what they can to adapt to changing circumstances and evolving patient needs. Certainly, those that do not do so need to be made aware of concerns about their behaviour and there can be many ways for such concerns to be communicated, including, of course, the Legislature of Ontario.

In closing, I ask you to pause and think through whether legislative prescription and the second-guessing it implies of the patient care provided by hospitals is the way to go. Although issues of comfort, convenience, equity in treatment, liability, efficiency and accountability can also be raised, we believe emphatically that safety must be our prime consideration for hospitals and staff.

Thank you, Mr Chair, and any one of us will be prepared to answer questions from the committee.

Mr Jim Wilson: Thank you, Mr O'Riordan and others for appearing before us today. I'm sure it would have been your preference that this issue not come this far.

Mr O'Riordan: Jim, I always like to see you. You know that.

Mr Jim Wilson: Perhaps you could just give me your interpretation, though, because you do mention it in your brief, about the phrase that in part says, "or any safety standards established by the authority responsible for the place where the person is receiving care." I really don't know what that means. Does that mean the hospital administration can still make up safety regulations or something like that?

Mr O'Riordan: It's a very good question, one we really leave hanging in the brief a little bit in that I'm not going to try to put words in Mr Ramsay's mouth about what he intended there. I imagine, from the conversations we've had with the member and with his staff, that he intended to indicate that there was some flexibility at the local level in terms of laying down regulations regarding size, placement and some of the other matters you raised earlier, but I would have to defer to the member to give you a direct answer on that.

Mr Jim Wilson: Perhaps Mr Ramsay would like to take the opportunity to respond to that, because it seems to me that it's the escape clause in the bill. What the OHA has told us is that for a variety of reasons, including safety, some hospitals now don't allow personal televisions. The way this bill is worded, it seems to me that you can have a TV, but if the local authorities say you can't—then why wouldn't they just impose some safety standards and prohibit it? I don't see how this is any different from the status quo.

Mr Dan Drown: In my understanding, what a hospital would do in terms of imposing a safety standard would be a standard that would be compatible with the operation of a public hospital.

This, while making the allowance for a personal TV, would also perhaps encompass rewiring, things like that, to make it acceptable. We're quite uncertain about whether the cost effect of that would be any different than through systems that are already set up which might well need to be made flexible and changed. As I believe the Sampsons pointed out, they did speak with Sterivision, who were willing to provide a larger-screen TV to accommodate the vision issue, within the safety regulations that apparently the hospital has, and they were willing to pay for that. That met the safety regulation.

Incoming personal-use items may have to be modified. I don't know. They are frequently designed for home use, not for the distances and the placement within a hospital room, which can be quite small, given two to four beds, as they're designed.

Mr Jim Wilson: Has the hospital association had a number of complaints about TVs in rooms now being too small? Give us your honest assessment of what the lay of the land is with respect to this issue.

Mr O'Riordan: I can't say that we have, until the matters were raised by the member. I don't think we've had correspondence on it. Dan is closer to the issue, so he may want to respond.

Mr Drown: I think it's safe to say we have not had any indication that this is a system-wide problem. As Mr Ramsay knows, there was a survey done, and there's any number of policies which across the board seem to be

managed effectively within individual hospitals' purviews in providing, hopefully, what patients need in addition to their medical needs; we're now talking about comfort and support they might require. There has been no other instance that I'm aware of, in an exhaustive search of each hospital to see what's there.

Trying to impose a standard across a system as diverse as this, from smaller hospitals in northern communities to downtown, central-core hospitals, makes it very difficult to please absolutely everyone, especially over the long period of time these people are in hospital for.

Mr Randy R. Hope (Chatham-Kent): Maybe I've misunderstood some of the comments you make in reference to the member who introduced the bill, because you set the appropriate political tone but then I read the comments you make and you make political statements too.

I was listening to the presenters before you talk about an issue they have, putting in a 14-inch television. Knowing the state of technology today, that you can get a combined VCR and 14-inch television for \$589 and can install that right on the mounts you're talking about, I can't understand why the people were not entitled to do this. You don't need a separate VCR and television; you can purchase it all in one. I used \$589 because I was pricing them for my van. You can automatically put those on the proper brackets, which are not on the floor.

Then you come before this committee and ask, is it proper for us to make a decision on this piece of legislation? I'm saying yes, because I listened to the answer about the response to the letter, that "We don't want a precedent set" so there was no opportunity to solve the problem, and I know the technology is out there.

1640

I take exception to some of your regulatory issues. You've clearly underlined the issue of the social contract and the Consent to Treatment Act, which I take exception to. But when I look at this as a basic issue and ask, "Do we need legislation?" the answer is yes. If somebody's not willing to make a decision, somebody has to make a decision for individuals.

I believe it can meet all standards. The questions you've raised today about health and safety—it's in your brief about the floor space—are inappropriate because there is the technology. I understand the gentleman's concern about providing for his wife. He's willing to spend that little bit of money, would buy a 14-inch television with a built-in VCR and would provide everything, and it would still flow out the same way the current system does.

I sat here and listened to what you said and I listened to the presentation before. Let me tell you, I understood where Mr Ramsay was coming from when he presented the bill, but I'm now becoming more clear, with more support for Mr Ramsay. By the presentation made today, I don't think we're after the best interests of resolving.

I make those statements and I do allow you the opportunity to respond, because I did take a few shots. But I now believe, just from listening to the OHA's presentation, that we are going to have to do something to ensure there is a resolution mechanism in place for people. I'm

sorry, I've just got to say that.

Mr Drown: I question whether the resolution of assistance across the board requires legislation, or whether, where we have policies in place which seem to be working and potentially accommodating the needs of patients for appropriate-sized television—in other words, we're speaking of one instance where there are problems, and we're speaking of a number of policies across the province which indeed seem to accommodate the needs of the patients satisfactorily. This bill would effectively eliminate those policies by bringing in personal televisions. I think this must be resolved at the local level as a part of administrative and hospital board management.

Mr Hope: No, what this legislation will do is set minimum standards to allow access for individuals. If hospitals say they provide bigger televisions, a 16-inch screen or whatever, in the rooms, so be it, but that becomes an additional standard of the legislation. This will put in place a minimum standard which will ensure you don't have the headache of going through this rigmarole. If hospitals want to supersede the legislative requirement, they're more than able to do so, but it does set a minimum standard, because there's no standard in place right now; it's left to the individual hospitals' policies, not a minimum provincial standard which says this is the way we go at it.

Mr Drown: I don't see the standard-setting within the policy. I see it as a bill which allows people to bring in videocassette recorders and television sets without much restriction or governance upon that.

Mr O'Connor: I appreciate your coming to address this. I agree that it probably should have been dealt with at the local level and that there should have been discussions taking place there. It's unfortunate that we had to bring the Sampsons down from Kirkland Lake to address it—I don't think we should have had to do that—but given that they're here and that we have this before us, there are a few things that perhaps aren't clear in the legislation. We'll talk about that later on, as we get into the clause-by-clause element of this.

I can see where there could be some problems, when we talk about people in long-term care facilities having televisions and trying to get consent from other patients in the room who might be affected. I could see why it would be important that there be some discussion and dialogue there. I know that all long-term care facilities, when they place new residents, go through a process when sometimes people don't quite get along so well, and there is a little bit of allowance made and maybe some changes made.

I wondered about the health and safety standards you talk about here. Have there been health and safety issues brought up by your membership? You've pointed that out as a reason for this and I wondered if you'd explain why you've used that as part of your rationale.

Mr Drown: I'll ask Jim Armstrong to comment from the Queen Elizabeth point of view, but I would also go back to the fundamental statement that patient safety within a hospital environment is the responsibility of the hospital and the hospital board, and it goes no further than that. You're right in asking for clarification, but

what we are dealing with is a health care environment where medically necessary services are being provided that make it slightly more complicated than a home room, which indeed people sometimes come to view this as.

Jim might have some observations on the safety issues which have arisen in their experience at Queen Elizabeth Hospital.

Mr Jim Armstrong: Our policy goes back about 17 years, prior to which personal TVs were allowed. I have been there 16 years, so I can't comment too much on the distant past, but I can comment on why we went in the direction we're in now.

It was specifically because of safety concerns, the variation in how TVs were being taken care of, the various technicians who had to come into the hospital for private TVs and so forth.

We went, when we moved to hospital-owned TVs, to a rather large-screen television, about 21 inches I believe, pedestal-mounted, which at that time seemed to be the right way to go. These TVs had a lengthy umbilical cord which carried power, and strapped to that the cable signal. They went from the head of the bed down around the bed, or under the bed or whatever configuration was possible in the circumstance, to the TV generally at one corner of the foot of the bed, and they very quickly became a major problem. They were difficult in terms of care. It was difficult in terms of moving the beds for cleaning and other purposes. We found that the cables were constantly being pulled out of the wall and the plugs damaged, and with the beds running over the cable, consistently they would become damaged and broken. At times they became tangled up in the bed rails.

So having dealt with that system for a portion of the contract period, we had a reopener available and decided to get out of that particular game. We had those televisions knocked over, injuring staff and so forth. We had vases and coffee cups set on top of them and spilled into the back of the set, with resultant smoke and so forth.

What we opted for, in consideration of the safety issues, was for a more typical hospital system, a smaller-screen TV, a nine-inch TV made by Bunting Bell—it's actually a Zenith television set—designed more or less for the purpose of hospital use. We specified it had to be a 24-volt television set—these particular sets had to be altered to that—and we wanted them arm-mounted so they would be coming off the wall behind the bed. In this configuration, both the 24 volts and the cable signal are carried by one coaxial cable which runs up through the arm and down to the set, so in case there's any pinching in that arm or anything at the television end that breaks or becomes available to the patient, they're subjected only to a very minor shock, not 120 volts. It's run off a power pack mounted on the wall behind the bed, which is also fused in case of any power surges.

I wouldn't pretend these televisions are perfect, not by any means, but they do swing up out of the way in cases of patient care or the need to move a bed and so forth. They are CSA-approved sets, all the alterations are CSA approved, and we have had no incidents with them in terms of safety issues since they went in.

The theory behind a small-screen TV, which I neither defend nor acknowledge, just present, is that when a smaller-screen TV is close to your face, the visual viewing area is about the same as the larger-screen TV further off. That's why the smaller-screen TV people will tell you that's adequate.

We have somewhat newer models that we're now using that come from Granada. Both of these sets are fully capable, unlike the sets in Kirkland Lake—ours would carry many channels—and our newer sets are about a 10-inch set, so there's a slight improvement there.

Physically we have two sites in our situation to have ceiling mounts, and other individual considerations would be very difficult. For us at least, this particular consideration is clearly the way to go. Our costs are not nearly what Kirkland Lake's are either, because we own the television sets.

1650

Mr O'Connor: Yes, and it's also a very large hospital, in comparison.

Very early in your opening remarks, you mentioned that when the member for Timiskaming introduced this bill and sponsored it—I don't know if it was an inference or what—you wished there had been more opportunity for dialogue then. If you'd had the chance for more direct input into what Mr Ramsay would bring forward—he felt this was the only way of remedying this situation—what else would you have suggested he include in the bill?

Mr O'Riordan: First of all, the OHA is of course not a regulatory body. We don't have that kind of power over our members. It's still a voluntary association. All hospitals do belong, but it's not a closed shop. But we would in the circumstance have attempted, if we could have, to try some mediation of the situation. Once the bill was introduced, I guess on the one hand it appears like a solution, but on the other hand it tends to polarize the situation a bit in terms of the individual hospital member that may have felt they were being spotlighted by this.

Mr Drown: We've consulted with some of the chronic care task force, which represents both acute hospitals that have chronic units and the freestanding hospitals, and they do see this as an individual hospital matter. We don't have the power to enforce or control what individual hospitals do. On occasion, there might be the opportunity to mediate an individual situation, if it's called to our attention, in terms of trying to help something. In this case I don't know if that would've been helpful.

But what we are seeing is that over 200 hospitals, about 145 of which have chronic care beds, do not seem to have difficulty administering at the local level policies which try to recognize a patient's needs in the various configurations of the units we find, which range from about eight beds in some facilities to as many as 200 in the large size of Queen Elizabeth Hospital. We see the range of things. We concluded that we can't write the perfect policy perhaps; we can only do what we can to ensure that the fundamental concept of patient safety is given the sensitivity of following patient comfort needs as well.

Mr O'Connor: If that resolution couldn't have been

found up in Kirkland Lake, do you think there was the possibility that this could have been dealt with in a regulatory fashion within the hospitals act? I don't know; I'm asking for your thoughts on this. Do you think this could have been dealt with in a regulatory fashion if the dialogue had ended in Kirkland Lake?

Mr Drown: Again, the issue of going before a hospital board and the use of those vehicles one would have thought would have remedied or found some compromise. I can't comment on what happened. It's obviously been some period of time and they feel their policy is correct. I don't think there's an enforcement of that, as there isn't in many other instances, in terms of patient comfort needs contained in the Public Hospitals Act.

Mr Jim Wilson: I just want to get the witnesses' opinion about something before they have to leave us; that is, I think the explanatory note in this bill doesn't match the contents of the bill, given that it talks about that patients have a right to install their own television.

But it would be my opinion, and I'm just wondering what the hospital association has to say, that the way the bill is worded in clause 1, the Kirkland Lake hospital administration or board still wouldn't have to allow personal television sets and VCRs, given that they could simply pass some safety standards policies and, at the end of the day, this bill doesn't do what it is billed to do because it's not an absolute right prescribed here. Would you like to comment on that?

I gather from your presentation that it's: "Why put us through these hoops when we have policies in place in local hospitals now? If you want us to go back and make up some safety standards..." All you would need is a letter from the staff, for example, or the nursing staff saying, "These TVs are in the way." That would be enough excuse to not have them, the way this bill—it says, "any safety standards." This is the most wide-open piece of legislation I've ever seen. So what's your opinion on what I think this bill does, which is good politics?

Mr O'Riordan: I guess we're getting into a very speculative area. But clearly, as you say, if a joint workplace health and safety committee identified this as a difficulty, if there was smoke coming out of the back of the TV, as happened at the Queen Elizabeth Hospital, or Mr Sampson, I think, talked about "there was not much of a tripping hazard" involved with the wiring—that would not be sufficient for a joint workplace health and safety committee.

I think in their analysis and in their view of the situation, their goal, as we know, in workplaces is to eliminate the hazard, to prevent the hazard, not to just simply ensure to the staff that there's "not much" of a hazard.

I would think that hospitals would not frivolously put in place safety standards, but I think those that currently prohibit the use of personal televisions, in our view, are doing so for good reasons, are doing so for sound reasons, and would likely continue those policies through the creation of safety standards or the enforcement of current standards.

Mr Ramsay: I'd like to come to that question before I make some other comments.

The reason for that provision, to talk about local safety standards, was that the Kirkland Lake hospital cited as one of their reasons for not allowing individual televisions in the rooms that they have their own safety standard policy. The reason given, which I felt was valid, is that there may be some interference given off by older model TVs to some of the new, sophisticated monitoring devices that are installed in some hospital rooms. Obviously, that would cause a health and a safety hazard, and there would have to be some standards set in each hospital as to the type of equipment they have and the compatibility with residential-type electronic equipment. That's why that provision is put there.

If I could just sum up, we've had a lot of highly technical discussion here and a lot of discussion based on institutions. Obviously a hospital is an institution. You will notice in the very first sentence, in the first clause, I have only talked about one part of the hospital, and that's the chronic care part, because I think the chronic care part of the hospital is not necessarily business as usual. Really, this is a home for people. I think we have to strive to try to make a chronic care setting in health care more of a home setting.

I know there's a tension here between running an institution and trying to make sure the institution runs effectively and efficiently. At the same time, it is a caring business. I think that's got to be uppermost.

These things don't move along unless you have advocates. I know you haven't been absolutely overwhelmed with complaints at the OHA and, quite frankly, I don't expect you to mediate on my behalf with an individual hospital, because each hospital is free to make up its own policies and it's probably not your part in the piece to be representing me or my constituents at the Kirkland Lake hospital. They have the perfect right to set their own policies.

But it's for advocacy, such as a private member's bill as a medium, to try to bring the issue to light and to try to strike some advance for patients' rights. It's not about televisions; it's about patients' rights in chronic care wards and about trying to make it more of a home for people, more of a humane setting.

1700

I guess in everything we try to do there's always a balance. We wish hospitals could generate all their revenues to ease the tax burden. That would be nice to do, but we have to find a balance between the taxpayer's contribution and what the hospitals can generate through their own cash-generating revenues. That's why I bring this forward, and I ask the committee to support this bill.

Mr O'Riordan: I think what we have here is to a certain extent a collision of rights. There are certainly the rights of the patients; there are also the rights of fellow patients and their families and the rights of workers in the hospital and administrators, and I think we do have a classic sort of collision that way.

I don't envy your task in sorting it all out this afternoon, but I do want to indicate that we are very sensitive, and I think Mr Ramsay has achieved his purpose in some ways in that I think he has sensitized a number of people

in the community and within our sector to the importance of the issue. I think he's to be commended for that.

We cannot agree with his solution, necessarily, but I think if this is the purpose of a private member's bill, to a large extent that probably has been achieved.

Mr O'Connor: I would like to ask one further to what I was asking earlier about long-term care, some of the regulations that will be coming about as a result of legislation around long-term care and chronic care and what not, if you could see an area where this could be regulated in that fashion that would achieve the results Mr Ramsay would like to set forth as a way of providing some reasonable way this could be dealt with so that the patients do have some choices here. I don't know whether there is or there isn't; I just pose that as a question to you.

Mr Drown: I would only say the hospital environment as we know it is one where safety and comfort have to be paramount, I think, bearing in mind, as you said, that the whole chronic care role study which has been supported for change will introduce a very different kind of patient obtaining chronic care services over time.

These people will be more medically unstable than they are at the moment, and I think perhaps we'll need different technologies than we have right now to attest to and attend to their comfort needs, along with the fundamental reason why they're in a public hospital, and that's to receive fairly complex medical treatment. This issue needs to be, obviously, attended to using the best of technology in the best way that can be implemented.

However, we can't stray from the fact that increasingly the delivery provided in chronic care beds will become much more to medically complex patients as government initiatives are taking their place to do that. These have been changes that have been supported by all parties of the government for a number of years, and I think that this issue exemplifies where, to cast in legislation something that has to be modified, I don't think that will correct it. It will be corrected by attending to the patient needs the best way they can in the local circumstances.

Mr Hope: I was listening to the presentation, and being one who plays with electronics, I believe that a normal TV can be converted to be adaptable to the packs that they were talking about. Just a general question: Are we done with this bill today or is it on longer?

The Vice-Chair: We're proceeding to clause-by-clause now to complete the bill.

Mr Jim Wilson: Before we do that, I have a question for legislative counsel, if counsel would like to join us.

The question is similar to the one I posed to the Ontario Hospital Association in my latter comments, and that is, can you just give us a clarification of any safety standards established by the authority responsible for the place where the person is receiving care? In my reading of that, this bill may not do what the Sampsons want it to do, and I don't want anyone to get any false hopes here.

Mr Christopher Wernham: For the record, Chris Wernham, legislative counsel. Would you mind repeating the last part of your question?

Mr Jim Wilson: First of all, here's my opinion. Tell

me if I'm right or wrong. There's not an absolute right established here to install your own personal television or VCR, because that right is limited by CSA standards or any other standards that may be set by the local authority, I gather being the administration of a hospital.

Mr Wernham: That's correct.

Mr Jim Wilson: What type of local standards would be acceptable? Mr Ramsay talked about electronic interference. I could see if some of the staff complained to administration that so-and-so's TV set is very often in the way of the staff performing their duties. I know we're in the area of speculation here, but would that be something then that the board or the administration of the hospital then could say, "Well, okay, so-and-so doesn't get a TV," or, "We're going back to our old policy of just using the TVs that the hospital provides and not your personal TVs." It seems to me it's a very flimsy and open piece of legislation here.

And the thing is, I should just comment, Mr Chairman, that this thing very well could pass, so we want to be careful it's acting on what we're voting on here.

Mr Wernham: I'm sorry, but I can't comment on the policy aspects of the bill. I don't know what is involved with respect to interference with other patients.

Mr Jim Wilson: It says, "or any safety standards." Does anybody know what the heck that means?

Mr Wernham: As the bill states, these would be standards established by whoever is responsible for the chronic care place.

Mr Ramsay: I'd like to try to give an answer to Mr Wilson. You're right, there is no absolute right through this piece of legislation, because I feel it would be irresponsible to disregard safety standards that might have to be accounted for in varying institutions.

As the Ontario Hospital Association had stated, we have an incredible variety of chronic care institutions in Ontario. Some are very modern and some are very old. We have wards with six or eight people. We have private rooms. There are all sorts of different things that have to be taken into account in an individual hospital.

Each hospital has its own safety requirements based on the plant that they operate and I would not want to override through a piece of provincial legislation the individual safety concerns that a hospital would have.

I bring this forward in good faith, that hospitals do have their safety policy and would not invent safety policies in order to circumvent the law in Ontario that people in chronic care wards be allowed to have their own TV or combination TV-VCR. But to be responsible, there are very different circumstances in different hospitals and safety standards have to be paramount in delivering this sort of service or any service.

Mr Jim Wilson: I agree with Mr Ramsay. In good faith, I don't think they will, but say they just want to stick to their guns and not allow personal TVs and VCRs and they brought forward a set of safety standards to justify that position. Then this bill would at least give chronic care patients the right to go to court and argue that in front of a judge.

Mr Wernham: I would think so, yes.

Mr Jim Wilson: Then the courts could decide whether it's frivolous or not on behalf of the hospital.

Mr Wernham: Correct.

1710

Mr Hope: Good Lord, I wouldn't want to go to court over a television, and I think this is what we're trying to get at. I agree with Mr Ramsay.

I listened to the conversation the OHA just made, that they would have loved to have been involved in the discussions or have been a mediator. Well, this is a perfect opportunity to do that. If we were to amend this bill by adding a section which puts into place a provincial, regulated standard, it does meet the electrical aspect you're talking about, making sure the wires are off the floor and all that. You can look at a hang-up approach, where the individual can do it.

A simple amendment in this bill will give the regulatory power to develop a provincial standard, and then the OHA, as the representative body of all the hospitals, the government and Mr Ramsay can sit down, and people will not have to go to court because there will be a set standard that will deal with the hospitals' health and safety issues. What I heard from the brief was wires on the floor, tripping, in the way. I didn't hear much about technical interference with machinery used in hospitals. You can simply develop it.

What puzzles me the most is why this thing's even here. The TV the individuals went to Mr Ramsay about can be put on that same mount, right into the same box and everything. They would have their TV and VCR and it would still swing off to the side out of the way and the person would be able to see what was on television. It just puzzles me that this is here.

I'm asking, how can I guarantee that without some individual having to go to court—which lawyers just get rich from. The process is to put a amendment into this act which will allow a provincial regulatory standard that will take in the health and safety concerns of the workers and also of the hospital, so you don't get into whether a hospital can try to play games with this issue. We're not talking about playing games. We're talking about providing a basic thing for individuals, called a TV and a VCR, a little bit of pleasure they have left in their lives, trying to make their days worthwhile.

Good Lord, we can do it very simply by putting in an amendment which gives the regulatory power. The OHA—I heard them; I'd have to check Hansard—was very clear about working this thing out. Come to the table and let's develop those regulatory standards and let's get them in place so we never have to deal with this issue again, nor do we have to see any individual go to court to challenge whether they can have a 14-inch TV with a VCR in their room to provide comfort.

Ms Jenny Carter (Peterborough): I'm a little puzzled by this whole issue. It seems on the one hand we've got a specific instance and on the other hand we've got a law that's going to apply to all of Ontario. I have the feeling that the best solution to this is going to be hospitals making a decision on the spot about whether a particular case warrants an exemption from the general

provisions. I should have thought that was the way to deal with it.

I'm also a bit puzzled about the fact that you may have safety standards laid down in the act but the objection to a particular person having a particular TV may be that it's annoying other people in the room or something of that nature, in which case the right to have it would override those objections, according to what we have here. It just doesn't seem to add up.

Mr Ramsay: I can answer that and other questions about why we would need a law by giving some quotes, both for and against, from Ontario hospitals to show you the divergence of view out there.

On the against side, this is a quote: "Listen, we're not running an entertainment centre here. We're trying to run a hospital." This is from a northern Ontario hospital.

Another quote: "We've never had anyone ask us for their own personal TV, and we don't encourage it. If one gets it, they'll all want it."

Another one: "Are you kidding? This place is looking for every penny it can get." That's a Toronto hospital.

So that's how extreme some of it is.

On the pro side: "Of course they are allowed the choice to use their own television or VCR, as long as the equipment they bring into their rooms is CSA-approved. Our policy is that exceptions are made for our chronic care patients. The cable company comes in and hooks it up" etc and they even have their own phone lines. That's a hospital in Guelph.

A hospital in Toronto: "Our three-year contract with the TV rental company expires this year, at which time we will change our policy. Chronic care patients will then be allowed to bring in their own equipment. We have discussed the matter and feel that this is a quality-of-life issue. It really is ludicrous that some of our chronic care patients must pay a significant portion of their income to rent a small-screen television."

Another one: "The people on our chronic care floors are not considered patients; rather, they are residents who have made their hospital room their personal home. Thus, we allow TVs and VCRs as long as they are deemed to be safe by our maintenance staff." Again, this is why local regulation. "A safety log is kept on the equipment, and if the resident shares a room, we request that they use earphones."

Another one: "We make every effort to turn chronic care rooms into homes. That would include TVs and VCRs, if requested, and even personal furniture and wall hangings, but with some minor restrictions with respect to size and safety."

I've got another one here from Thunder Bay, but it's the diversity of the view in this that makes it quite a concern to me that there really are some people who are tremendously caring about these patients and others who say, "Forget it."

Ms Carter: I can see there's a problem, but I'm not sure this law is going to solve it. I also wondered why, in the specific instance we're talking about here, the suggestion that a 14-inch television would be provided by the company was turned down by the hospital.

In the letter, "To Whom It May Concern," Sterivision was receptive to the suggestion that arrangements could be made for a TV with a larger screen. It was agreed, providing the hospital administration would allow it, that they would supply a 14-inch TV with remote control at no extra charge. This proposal was brought to Mr Girkey and this was refused as well. There has to be a reason behind that and I'm wondering what that reason was.

Mr Lawrence Sampson: The same reason I told you initially. He did not want to set a precedent, period. That's the only answer I can give you because that's what I was given.

Ms Carter: It seems to me that what we need is for hospitals to have their own regulations, but be able to make an exception where it seems to be warranted and make that stick.

Mr Lawrence Sampson: If the hospital in Kirkland Lake is allowed the option of making its own regulations, nothing will come of this bill, nothing. We're here for nothing and you're here for nothing.

Ms Carter: We're going round in circles on this.

Mr Lawrence Sampson: These people have to be shown that other people besides the hospital administration have concerns in their life as well. We're not talking money here, we're talking my mother's rights, and I feel she is really being denied. She spent a whole lifetime raising her children. This is her last stop. Let's give her a chance, for crying out loud. That's how I feel.

Mr O'Connor: It seems to me that we're now coming to the point, in terms of chronic care, long-term care in these facilities, that we're looking at the residents therein as consumers and trying to be easy to get along with and cooperative in order to please the consumer. If the hospital is providing a service and has a consumer, would you not think they would want to try to please the consumer a little more?

Mr Lawrence Sampson: Actually, the hospital really isn't supplying the television system. Sterivision is supplying the consumer.

Mr Thomas Sampson: This is just for chronic care people who are not able to look after themselves.

Mr Lawrence Sampson: In Kirkland Lake we might be talking another two, three or four individuals who might want their own television. Maybe the rest of them are not capable of watching television or whatever. We're not talking a whole major deal here; we're talking a few individuals.

The Vice-Chair: Thank you very much for your presentation. We appreciate it.

The committee will now proceed to clause-by-clause consideration of the bill.

Mr Hope: Mr Chair, it's Mr Ramsay's bill, and I want to point something out to him. I mentioned an amendment to section 1 that would give a regulatory standard, and I'd have to check the record, but the OHA clearly indicated that to put in a provincial standard—even you said it—some will supersede that provincial standard, but at least you will not get into that complicated area. If you were to amend the order in council, or

whoever has an opportunity to regulate a provincial standard, it might be more appropriate to deal with the legal aspect of making sure this thing can move ahead versus just another roadblock. With an amendment in section 1 of the bill to allow order in council or whatever to have regulatory standards put in place, that way the OHA can be a partner in the standards, which will be a minimum standard for the province.

Mr Ramsay: I appreciate the friendly amendment coming from the member opposite. I'm not sure that's the OHA's real concern with this thing. To them, there shouldn't be an Ontario directive to this principle at all. I think their point of view is that each individual hospital board should make its own policy when it comes to this sort of item, and that's where we certainly disagree. I'm not sure that amending the bill to place more details with regard to safety standards is going to make it more palatable to the other side.

Mr Hope: At least they can't say you closed the door on them. It does allow an opportunity to put that standard in place, and that's what I heard, that they were willing to play a mediated process. They clearly made a statement about when you notified them and how much time you gave them. I'm just saying here's a little more time to make reality come true, and you don't get caught up in a legal process or a hospital playing games, if some regulated powers are there. I'm saying there's still opportunity.

Mr Ramsay: I appreciate that. What I've tried to do is to still respect individual hospitals' needs to set their own standards, and that's why I've set the tone of the bill the way I have. Unlike other comments that were made here, I certainly have faith that the hospital trustees will set their own standards in regard to safety and for no other intent.

Mr Hope: We can always refer back to Hansard in the future when we have to figure it out. I would love to see the amendment put in place, but if Mr Ramsay is not willing to do so, I can still support the bill as put forward.

Mr O'Connor: In the wording of the bill, should it not be "Canadian Standards Association" instead of "Safety Association"? Is that what you were referring to there?

Mr Ramsay: That's right. I'll so move that amendment, Mr Chair.

The Vice-Chair: It's been moved by Mr Ramsay that section 1 of the bill be amended to change the word "Safety" to "Standards" in the sixth line. Is it agreed that the amendment carry? Carried.

Shall section 1, as amended, carry? Carried.

Shall section 2 carry? Carried.

Shall section 3, short title, carry? Carried.

Shall the title of the bill carry? Carried.

Shall I report Bill 18 to the House, as amended? Agreed.

That completes the bill. Thank you for your time.

The committee adjourned at 1724.

CONTENTS

Monday 6 June 1994

Chronic Care Patients' Television Act, 1993, Bill 18, Mr Ramsay / Loi de 1993 sur l'installation de téléviseurs appartenant à des malades chroniques, projet de loi 18, M. Ramsay	S-1567
Lawrence Sampson; Thomas Sampson	S-1567
Ontario Hospital Association	S-1570
Brian O'Riordan, director, government relations	
Dan Drown, senior consultant, chronic care mental health and rehabilitation division	
Jim Armstrong, vice-president, operations, Queen Elizabeth Hospital	

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Chair / Président: Beer, Charles (York-Mackenzie L)

***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

*Carter, Jenny (Peterborough ND)

 Cunningham, Dianne (London North/-Nord PC)

*Hope, Randy R. (Chatham-Kent ND)

*Martin, Tony (Sault Ste Marie ND)

 McGuinty, Dalton (Ottawa South/-Sud L)

*O'Connor, Larry (Durham-York ND)

*O'Neill, Yvonne (Ottawa-Rideau L)

 Owens, Stephen (Scarborough Centre ND)

*Rizzo, Tony (Oakwood ND)

*Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Ramsay, David (Timiskaming L) for Mr McGuinty

Wessenger, Paul (Simcoe Centre ND) for Mr Owens

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Wernham, Christopher, legislative counsel

CALON
XC12
-577

S-56



Government
Publication

S-56

ISSN 1180-3274

**Legislative Assembly
of Ontario**

Third Session, 35th Parliament

**Assemblée législative
de l'Ontario**

Troisième session, 35^e législature

**Official Report
of Debates
(Hansard)**

Tuesday 7 June 1994

**Journal
des débats
(Hansard)**

Mardi 7 juin 1994

**Standing committee on
social development**



**Comité permanent des
affaires sociales**

Children at risk

Enfants en situation de risque

Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944-1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Tuesday 7 June 1994

Mardi 7 juin 1994

The committee met at 1547 in room 151.

CHILDREN AT RISK

Consideration of a matter designated pursuant to standing order 125 relating to children "at risk."

The Chair (Mr Charles Beer): Good afternoon, ladies and gentlemen. Our first witness today is Dr Paul Steinhauer, who is chief of psychiatry at the Hospital for Sick Children in Toronto.

I just note for the committee members that you have received the second summary of the testimony that we've received on children at risk. Bob, is there anything you wanted to comment on?

Mr Bob Gardner: The second summary does have something a little different for members. We picked up at the last meeting, from Mrs O'Neill, to bold the recommendations that the particular witnesses have made to the committee. We thought it would be easier for you to collate and organize them. Mrs O'Neill said she was doing that on her own time, so that's a great idea. We've done that in the summary.

We'll also have some draft, at the Chair's direction, of the material that was discussed in the subcommittee the other day and, with a little luck, the evidence from today for members on Thursday before they leave.

SPARROW LANE ALLIANCE
COALITION FOR CHILDREN,
FAMILIES AND COMMUNITIES

The Chair: I note, Dr Steinhauer, that you wear a number of hats, and the other one that you're wearing today is as chair of the steering committee for the Sparrow Lake Alliance. While some know of that, I suspect you're going to tell us more about it in the course of your presentation.

Dr Paul Steinhauer: Thank you, Mr Beer. I should also point out that while I am a child psychiatrist and while I am at Sick Children's, I'm not the chief of child psychiatry at Sick Kids. You did hear from my chief, Susan Bradley, I believe last week.

The Chair: That's right. Sorry. We have so many chiefs around.

Dr Steinhauer: I'm here today representing two groups: the Sparrow Lake Alliance and the Coalition for Children, Families and Communities. I've prepared a handout for you and I'd like to just briefly take you through it.

In the front inside cover there is a one-page report card on how we're doing with our children and youth in this generation, and the references to that are to be found at the end of this in the paper Youth in the 80s and 90s.

Following the table of contents there is a description of the Sparrow Lake Alliance. This was published in 1992. It talks about the 11 professions that are involved from the seven service sectors and the government ministries with whom we have worked. It doesn't mention that today there are 320 members of the alliance and it now has good representation from teenagers and from parents as well as from its professional members.

Following that, there is a one-page letterhead from the Coalition for Children, Families and Communities. This is a group that was set up by 17 organizations, purely for public education, to make people aware of the needs of children in the community and to try to enlist them on the side of bringing about the kinds of changes that are needed to support families in the 1990s.

That is followed by two tables, a blue one and a pink one, which I'm going to refer to in the course of my talk.

I've ended up with a paper, Youth in the 80s and 90s, which I'm going to talk about a little bit later as well.

That is the background material that you can have after I'm finished. But what I would like to do is mention to you that I've been a child psychiatrist for 32 years now, and for 27 of those years I was feeling like the boy with his hand in the dike and I was seeing patients in an office and very much sticking to that.

In 1989, however, along came the Ontario Child Health Study, which, as you know, confirmed what a lot of people had been thinking for a long time. It found on an empirical basis that 18.6% of the kids in Ontario met the criteria for one psychiatric disorder; that of those that had one disorder, two thirds had two or more disorders; and that only one in six of those with a disorder was receiving any treatment.

When I heard that, it reminded me of the first professional meeting I ever went to as a resident, where the head of the organization compared a child psychiatrist to a man who's going to a mighty river where drowning bodies by the thousands are floating down and he has to decide, what is he going to do? Is he going to wade in and pick out a few and give them mouth-to-mouth resuscitation and leave the majority going by, or is he going to go back upstream and try to determine what the source is and stem this wastage at its source?

That metaphor left us really with two options: We could either get better at fishing bodies out more effectively and do better at reviving them—and that is basically what the Sparrow Lake Alliance has been trying to do, and because that's well described in the handout I gave you, I'm not going to go on with that further—or we could go back upstream and find out why so many kids are developmentally drowning these days, with

psychiatric disorders, with illiteracy, premature dropouts, poorly controlled aggression, violence and delinquency, rising rates of teenage suicide and accidents and rising rates of alienation. Can we go back upstream in order to get them off to a different and a better start, which is more likely to turn them into competent and resilient children, teenagers and adults?

I would ask you, if you would, to turn to the blue table in this handout, and I'd like to take you through it.

The blue table suggests that if children get off to a poor start and if they have poor outcomes, they're going to be poor outcomes for society as a whole.

If, for example, those children are raised in families that don't meet their attachment needs so that they develop problems in trusting and in relationships, they will turn into adults with chronic relationship problems within their families, in their workplaces, within society and when they begin to parent their kids.

And if they have school problems that lead them to drop out or leave them functionally illiterate, they will be poor job prospects as adults, they're more likely to be chronically dependent on society, we're likely to have to pay higher welfare costs and they're going to be predisposed to adult anti-social behaviour.

If we have kids who are alienated and anti-social and who have chronic emotional disorders, we're likely to be faced as a society with increased rates of vandalism, violence, teenage pregnancy and a need for costly services.

And if we have kids who don't learn to be productive, we're likely to be faced with adults who are chronically unemployed, with businesses who can't find the skilled workforce they need, which in turn will undermine industries and society's economic base and we'll be left with fewer resources to meet the increased cost of welfare and services.

You can look at this from top to bottom as well. The child who has attachment failure and who doesn't develop trusting relationships is more likely to have school problems, is more likely to develop in an anti-social trajectory and is less likely to be productive in adult life. So poor outcomes for children mean poor outcomes for society.

We know a lot about what it takes to raise competent and resilient kids. We're not operating in a vacuum.

If you take a look at the pink table, the pink table lists what children's basic needs are. It talks about the prerequisites for meeting those needs. Then in the final column, it talks about what will happen if those needs are met at each stage and if they are not met. This is not just the Sparrow Lake Alliance talking. Everything I'm saying here has been said by the Ontario Child Health Study, the Canadian Institute for Advanced Research, the Carnegie Foundation, both Premier's councils, the Laidlaw Foundation children at risk project and the Vanier Institute of the Family. There's a virtual consensus about everything that is on that pink chart.

In 1980 I wrote a paper called *Youth in the 80s and 90s* in which I predicted that because of changes in societal and familial structure, we were going to see more teenage violence, more teenage suicide and more teenage alienation. I updated that in 1993, in the paper that's at

the back of your blue handout. I added a second section giving some statistics about what's happening with kids and families in 1993, and adding a third section which talks about what we as a society could do if we had the will to do something about it.

I think one of our big problems is that there are major changes in our family structure and in our societies which despite the best intentions of many parents are undermining the developmental prospects of far too many kids. As the Canadian Institute for Advanced Research and the Premier's Council have said, the problem today is that it isn't just high-risk kids who aren't making it; there are far too many kids who should be making it who are not making it.

The problem isn't beyond solution. We know a number of ways that we can effectively keep kids from drowning developmentally. Of course, the more we do so, the more we free resources for management of those whose disorders we can't prevent.

For example, France had a program where they wanted to cut down on the number of very-low-birthweight babies, and the way of doing that is ensuring the health of mothers throughout their pregnancies, ensuring their nutrition, ensuring they're off drugs and ensuring they get good medical care.

They paid every mother in France \$36 in order to get them to have at least four visits with a doctor over the course of their pregnancy. It was a fairly minimal thing. In spite of the cost and in spite of the fact that they gave that money to every woman in the country—they managed to enrol 99% of the mothers in France—they saved enough money when you consider that the medical costs in the first month or so of life of a very-low-birthweight baby are upwards of \$100,000, and there are continuing increased costs in education. These kids are much more likely to get into trouble with society, so they're less likely to become productive citizens and more likely to get into trouble with the law. They found that they saved money even on that broadly based a program.

Secondly, there's a home visiting program in Hawaii, in all of the outlying islands and in part of the main island, where they target every mother who has just had a child. They have a lay visitor who has some supervision go and give a questionnaire on the basis of which they separate these mothers into high risk for abusing their children and low risk for abusing their children. The ones who are considered high risk are intervened with and are referred to a number of appropriate services. They managed in this way to cut the risk of child abuse by 50%. If you cut the rate of child abuse by 50%, you also cut the rate of the school problems and the aggressive and violent problems that come from children who are abused by 50%.

1600

A third example: The Perry preschool project, which is an enriched preschool intervention, part of the Head Start program in the United States. I'm talking about this one because it's been meticulously followed up, and when they followed those kids up at age 19—and this was a program that stopped when these children were six—the kids who were in the program had only 40% the number of arrests and convictions of the children who had been

in the control group. They had only 42% the number of teenage pregnancies. Some 33% more of them had graduated and either had jobs or were getting further training. When they followed those through at age 27, they found that the arrests had been reduced by 50% and that those people who had been in this intervention had a significantly increased rate of earning and were significantly more connected to their families. So that's an intervention just at the preschool period.

What difference does it make how kids are performing at that very early level if development isn't like an escalator where, when you get on at one point, you always go in the same direction? S. Kellam of the National Institute of Mental Health pointed out that we know the characteristics of those kinds of kids who are able to succeed, academically and socially, despite growing up in conditions of extreme disadvantage.

First of all, they are kids who are social participants. They're not too shy on the one hand; they're not too aggressive on the other.

Secondly, these are kids who are able to contain their aggression and accept authority. If they can't get their aggression under control, they're going to be in trouble once they hit school.

Third, they are kids who have the ability to concentrate and pay attention and work independently. Recent work coming out of the Carnegie Foundation is suggesting that children who are very poorly parented in the first year or two of life are in a state of constant stress, as a result of which they have constantly high levels of cortisone in their bodies and that the cortisone interferes with the linking up of their neurological system, so that what you end up with are children who, as a result of continuing stress, end up with a defective nervous system that interferes with their cognitive development, their emotional development and their social development—irreversible change if children aren't well parented in the first two years.

Finally, these were kids who had identifiable areas of achievement.

Now, that doesn't mean that all children can or should necessarily be parented just by their biological parents. We know, for example, that 75-plus per cent of families require two incomes if they're going to stay above the poverty line. So when I'm talking about high-quality care giving, I'm talking about high-quality care giving either in or outside of their families, and I want to take a look at the effects of high-quality child care on children who are growing up in a disadvantaged situation.

High-quality child care increases their social competence; it increases their language and play development; it helps them get better impulse control so that they can self-regulate themselves better; they are more compliant with adult requests; they have fewer behaviour problems in grade 1, as rated by their teachers, and it helps compensate for the cognitive, emotional and social deficits that kids from disadvantage usually bring to grade 1.

On the other hand, if you take a child who is marginally or poorly parented and put him in poor child care, he will be more negative in his social interactions, both with his peers and with his teachers, he will have more language delays and he will have poorer academic performance.

You might say: "What does it matter how kids function at the grade 1 level? Development isn't fixed for all time." Kids can make up, it's quite true; kids do have some innate resilience, some more so than others, and kids can often make up for a poor start. But as John Bowlby has said, the kid who has been off to a poor start, often as a result of that is more likely to have increasing difficulties later on, and as Dan Offord has pointed out, once a kid is in a trajectory that is heading towards school failure or delinquency, turning him around may be like trying to take an 18-wheel tractor-trailer going at 100 kilometres an hour and expecting it to do a fast U-turn.

If you look at one example of this, the precursors of substance abuse in adolescents at the grade 1 level, 5% of withdrawn kids become substance abusers, 40% of aggressive kids become substance abusers, 60% of kids who are both withdrawn and aggressive—that is, the angry loners—become substance abusers. So the pattern that a kid is showing by grade 1 can have major implications, and that all presses in the direction of trying to get kids off to a good start.

Let's talk about schools for a minute. We know about the kinds of schools that can salvage and turn around some kids who are already on a path towards delinquency or illiteracy or dropping out, and I would suggest here the work of Charles Comer in New Haven and some of the work that Michael Rutter has done in England.

What Comer did was he took the worst schools in the city of New Haven, which is a large inner city with Yale University like a jewel in the middle of it, and he moved mental health teams into the schools. They did not treat the kids directly; their main job was to work with the teachers to help them understand the kids, to help them understand the community, to build bridges between the school and the community and to get the parents comfortable with coming into the school and having them welcomed within the schools.

What he found was that, within three years, his demonstration schools were third and fifth in the city academically, well above the controls, they had had no serious behaviour problems and they kept that for 15 years. The staff morale and their energies and their expectations of the children were the major changes. They found it wasn't that they had any spiffy techniques to offer; it was the fact that they helped these teachers see that these kids could learn and could be expected to learn, and that the teachers felt empowered to help them learn and the teachers and parents became allies in the education of the kids.

I'm not suggesting for a moment that our school system is entirely responsible for how kids are doing in school, because there are good empirical studies to show that how children do in school is more a function of what's going on in their family than of what's going on in their school, and I'm thinking here of how well did the family prepare the child for school—cognitively, socially, emotionally—how well are they continuing to motivate the child, and how are they supporting the child and supervising his homework. As a result, it's no wonder that empirical studies show that at age 14 the family has more influence on children's school performance, especi-

ally in English and history, than does the school.

One other very important finding in terms of one of the problems in our society where we often have children spending long periods of time either alone or after school when both parents are working: Time alone and unsupervised at noon and after school at the junior high level is significantly correlated with increased drug intake in adolescence and with decreased academic performance. Kids who have fathers who are involved with them emotionally and are strict but fair are twice as likely to do well and only half as likely to do poorly.

There's no doubt about it: If we have outstanding services like the four models that I've talked with you about, these will help, but we need more than just exemplary mainstream, let alone specialized, services if we're going to do a better job at raising the next generation of children. We need parents who recognize that parenting needs to be an active and not a passive process. We've got to get beyond the fact that you can get by with a few minutes of quality time each week. Quality time doesn't happen when you plan it; quality time is something that happens when a parent and child are together and suddenly, at a particular point, the defences are down on both and they just connect with each other. I think we have to get parents to recognize that one of the things that is crucially important is that they have the time and the energy left to devote to their kids.

1610

I recently was talking in Windsor and I ran into an old camp friend, and he was bemoaning the fact that on a recent visit to Toronto he'd spent some time with his daughter and her husband and their kids. One of the kids was seven and was already in serious problems in school as well as a behaviour problem of his own, and then the younger kid was also becoming a behaviour problem in her own right. His comment was that time with father in that family meant being allowed in the room when father was watching a sports event on television. This just isn't good enough. Kids need more active parenting than that.

However, we also need people who can support parents, and I'm talking here about the kinds of networks and communities that people used to have in their extended families but to a large extent have been lost. When women went to work, their community became the people they worked with rather than the people in the neighbourhood whom they used to spend the day with.

As a result, what we need is to rebuild, somehow, communities, whether they be based on neighbourhood, whether they be based on people who work together, whether they be based on religious communities, whether they be based on communality of interest or whether they be based on common problems.

June Callwood once talked about growing up in Belle River and talked about how any adult in that community took on responsibility for any child's behaviour in that adult's point of view. I remember when I was a kid here in Toronto we would have been mortified going out on Hallowe'en if one of our parents had ever come with us when they were "shelling out." But what parent these days would ever dare to send their kids out on Hallowe'en without an adult in attendance to make sure that things were safe?

I think what happens, as Garbarino has pointed out, is if communities break down, it means that kids are raised in an isolated manner and parents are liberated from the bonds and constraints of community standards.

If parents are going to have more time, we need workplaces that are going to be less undermining of family life, workplaces that are going to allow no-hassle relief time, workplaces that are going to allow time for family crises, either with children or with aging parents, workplaces that will allow flexible work hours, that may allow work in the home, at a computer station in the home or that sort of thing, that may give advice to parents who are having problems with their children or their aging parents.

A lot of American companies and Bell Canada have found that when you have family-sensitive workplaces, they actually pay off for the company in terms of the increased morale and in terms of the company's ability to retain its workforce and not have to be retraining people all the time. Then we're going to have to come to grips with the global economy. We're going to have to come to grips with the fact that most people aren't going to have a lifelong job any more; that there are going to have to be changes to our educational system because people are going to have to be learning throughout their lifetime and retraining as the needs of the job market change; we're going to have to change so that our self-concept isn't based as exclusively on work, as it is, since more people are going to be out of work for longer periods of time; and we're going to have to do more with apprenticeships. We're also going to have to have changes at the government level because, as long as I can remember, our provincial government ministries and our various levels of government have never had a single, unified focus on the needs of children.

Instead, you've got separate ministries—Health, Community and Social Services, Education, Tourism and Recreation, the Attorney General—each of which is marching to its own drum, which is duplicating, which is competing with, which is guarding its turf, which is ignoring, which is reinventing the wheel and which is offloading responsibilities on to other ministries and on to other levels of government as it comes under financial constraints. Especially when times are bad and money is short, this tendency of the various ministries to bunker in and not cooperate for the sake of—you know, we used to have a secretariat that was going to try to keep people thinking together in planning services for children, and as you know it was disbanded. We now have a Premier's Council which has come out with an excellent report which I'm sure you're all familiar with, but the unfortunate word that we're getting from junior people in a number of the ministries is that the word from the top is, "The Premier's Council is looking after that integration stuff, which means we really don't have to worry about that too much."

Government will continue to be more a part of the problem than a part of the solution until such time as we have a solid commitment to a unified focus on children. No wonder Marion Boyd, when she was Minister of Community and Social Services, told us that despite all their talk about the importance of integration, ministries

will do more to fragment than to coordinate services for children until that kind of single focus is established.

Finally, I think we have to get across a recognition of the importance of all of us, as individuals, as leaders within particular groups within the community and as members of organizations, becoming involved in doing something about the problems of families and the problems of children. We just can't sit this one out. We're either part of the problem or we're part of the solution.

This has led to the foundation—it was originally set up by the Sparrow Lake Alliance, but the alliance is now just one of 17 partners—of the Coalition for Children, Families and Communities. This coalition has taken on the job of trying to make the community aware of the needs of children. It has done it by forging ongoing links with journalists such as Michael Valpy in the *Globe* and Mail and Leslie Scrivener and Nancy White in the *Star*. You may have seen the series in the *Sunday Star* for the last three Sundays. We've got two copies of the Scrivener series and copies of the series by Michael Valpy. We are hoping over a period of time to develop an awareness in the community, and we trust that if the community understands the issues, the community will join us in feeling that something has to be done about them.

One of the other things we have to do is help the community see some issues more clearly. For example, with the recent changes in the Young Offenders Act, one of the things we have heard has been screams from people who are saying that more and tougher sentencing is really all that's needed, with a complete negation of the importance of prevention. But empirical studies have shown again and again that if you punish kids and don't have a relationship with the kid you're punishing, the net result, if that punishment comes from a judicial system, is that the offender becomes more aggressive, more anti-social, more rebellious, he is more likely to reoffend, and you have the increased cost of keeping him in jail.

On the other hand, we've got to help people see that there are known antecedents of anti-social behaviour in children and youth, and we know what they are. They are poverty, they are failed attachments, they're father abandonment and they're anti-social behaviour of the parents, and these are some things that we can do something about.

So these are some of the issues that we think are really important, and I am speaking to you here really not as a psychiatrist, not as a representative of the Hospital for Sick Children, but as a representative of these two larger groups that have reached a consensus on the sorts of things that I'm talking about and that have reached a consensus with our colleagues in the Premier's Council, the Laidlaw children at risk group and the Canadian Institute for Advanced Research, which Fraser Mustard is representing.

The Chair: Thank you very much, Dr Steinhauer. I suspect that we could spend profitably a number of hours following up on the points you've made, but in the time we have available we'll try to explore at least some of them. We'll begin the questioning with Mrs O'Neill.

1620

Mrs Yvonne O'Neill (Ottawa-Rideau): Dr Steinhauer, I had an opportunity in the House today to talk

about people with experience and I said that I felt they had certain qualities that maybe some of us don't have. I'm going to repeat that because I think you have them: wisdom, perseverance, patience, mixed up with empathy. I hope you will accept that as a compliment.

I really feel that what you are saying is very practical; it's very clear. I'm very pleased that you brought forward the role of fathers. I think that's very important. I'm very pleased that you are somehow influencing the media, and I've noticed that. The importance of neighbourhoods also: I feel you highlighted that.

I have three or four quite brief questions.

You didn't really say Ministry of the Child. Are you talking that?

Dr Steinhauer: I don't know how practical it is to have a Ministry of the Child. But what I do know is that, for example, I'm spending Wednesday of next week, all day, at the Ministry of Health, which is developing a health promotion policy. This is after the Premier's Council report Yours, Mine and Ours has come out. Rather than trying to fall in line with that and see what the Ministry of Health can do to go along with it, they are taking 20 people for a whole day in order to reinvent the wheel—this kind of thinking.

In the past year, we've had policy reviews by the Ministry of Community and Social Services, the Ministry of Education and the Ministry of Health. They have all acted as if they were the only ministry involved with children, and that just isn't good enough. With the exception of two major programs that've been in place for years—and I'm talking about Helping Children Adjust and Better Beginnings, both of them excellent programs—those are the only real, effective interministerial collaborations. There is far too much of ministries going it on their own, sloughing responsibilities to other ministries developing comparable programs.

I don't know whether a Ministry of the Child in a province of this size is feasible, but certainly something has got to be done to get people to get serious about planning together. Maybe the answer is having communities decide how they are going to allot the funding to the various sorts of services. The danger in that, however, is that communities that are not affluent and articulate might lose out to other communities that are better able to fight for what they want.

Mrs O'Neill: The northern communities are aware of that. If you do make a decision on that, let us know.

My other questions are much more, I guess, practical. You didn't say much about the faculties of education or professional development of teachers in the school boards. I do know the social contract has had some effect on professional development days. Do you feel there is enough being done there in either of those two centres regarding teachers as significant partners?

Dr Steinhauer: I think teachers can have an extremely important role. I think teachers have to have a double role, because they are not going to be able to educate successfully those 20% or 30% of kids who come to school either with psychiatric problems and/or hungry and/or with emotional problems as the result of an abusive or conflicted family situation. So they're going to have to deal with psychosocial needs of those children

before they're going to be able to educate them.

I don't think personally, and I know the alliance and the Coalition for Children, Families and Communities don't think, that teacher education adequately prepares teachers for that, and I think in-service education probably isn't paying as much attention to the psychosocial aspects of teaching as it should.

Mrs O'Neill: Have either of those coalitions or committees you've been part of had faculties of education representation?

Dr Steinhauer: We have been in contact with faculties of education; we have not had members of faculties on the alliance. There is an education task force of the Sparrow Lake Alliance which has been talking about involving several of the staff of two faculties of education on a project looking at teacher training.

Mrs O'Neill: My last question is even more practical. You talked about lunchtime and after school being pretty significant in the child's day, and that if they spend that alone there are difficulties. Both as a student and then as a teacher the lunch-hours and after school were more structured than I think they are now. Do you feel it's worth pursuing those two times in the school day?

Dr Steinhauer: I think a sort of latchkey care centred around the school, possibly by other staff, by recreational staff, possibly by teachers—but I think the quality of supervision of those times is important. It's kids who are completely unsupervised and left on their own who are more likely to get into trouble.

I think one of the problems we get into is that at times these days you may have a day care centre, you may have a recreational program, you may have academic staff working with children of the same families out of the same school and they don't communicate with each other because there are status issues involved from the various ministries that are sponsoring them.

Mrs O'Neill: Have your groups, either of them, done an evaluation yet of Better Beginnings, Better Futures or the adjustment program?

Dr Steinhauer: Some of the people in our group are very much involved in the Better Beginnings program. As far as the Helping Children Adjust program, that was conceived actually at the founding meeting of Sparrow Lake and that story is told in that first handout that we've given you.

Mrs O'Neill: We had a very powerful representation here from the Better Beginnings, Better Futures program, which has gotten—what should I say—spinoffs that none of us could have imagined, and when you said that getting self-concept from work, people who are on social assistance, but who are making significant contributions to their communities, came forward very proudly and told us just how they've turned things around.

Dr Steinhauer: I think that can be wonderful for people like that. When I made that comment about work, what I meant is, I'm a number of things: I'm a psychiatrist, but I'm also a father; I'm also a husband; I'm also a member of a number of groups, and I think that my being a father and my being a husband are just as important a part of my worth as my professional status.

I think our society gives all its perks for how much you earn and the status of the job that you have, and I'm

saying that if the economists are right in saying that more people are going to be unemployed for more of the time, we can't have their entire self-esteem based on the job they're doing and the money they're bringing in. We've got to start thinking of that or we're going to have a lot of systemic depression.

Mrs O'Neill: Thank you for your common sense.

Mr Stephen Owens (Scarborough Centre): Dr Steinhauer, I apologize for missing the first part of your presentation, but I want to tell you that in terms of your theories with respect to unemployment and how we should be looking at ways to support the family, I heartily endorse them.

In my experience, both as a trade union president and now on the other side as a manager administering a collective agreement, it's my view that workers need to have that kind of support with respect to their families so that the family unit is taken care of but there's also a high level of productivity because there isn't the stress that accompanies a less hospitable environment for that.

I also think you're quite correct in your assessment about the kind of fundamental restructuring that's going on and how we have to redefine our definition of "work" and what makes a person worthy in the eyes of his and her fellow members of society. As you say, the perks have always been accorded to the \$100,000 and \$200,000 earner, but now as more and more people are becoming unemployed because technology has changed—there are also only so many refrigerators and so many VCRs and so many cars that people need—we're probably getting pretty close to maxing out in terms of the demand.

I guess I would like you to, from your perspective and your experience, make some recommendations to the committee that I and my caucus colleagues can take back to our government, particularly the Ministry of Labour, Ministry of Economic Development and Trade, to start working on those systemic issues that you've identified.

1630

Dr Steinhauer: I'm not sure to what extent government can persuade our major industries that it's in their best interests, as well as the province's best interests, for them to have more worker-friendly policies.

The vice-president in charge of industrial relations for Bell Canada, who sat on one of the committees of the Premier's Council with me, was saying he felt that if government tried to legislate this, it would be counterproductive. He felt that industry would do better if it got the message out to other people in industry that it can be better business to have worker-friendly workplaces.

The other thing you might think about is, are there ways where you can make it worth a company's while to have worker-friendly policies at a time when we've got good statistical evidence suggesting that half of the women who work and who still do the majority of the parenting are expressing significant stress as a result of that and a third of the men who have children are reporting that they have major stress because of it?

I'm not sure what government can do; I'm not sure what the unions can do; I'm not sure what the employers can do. I think one of the things we can do at first is make it an issue, that the result of this is that too many

parents are coming home absolutely bushed at the end of the day and they don't have the time or the energy to do anything but shush their kids up.

It's a very solid theory of child development that if kids find that they're getting less of the nurturing and that the only time they hear from their parents are when they're being pushed to do this or told to go to bed or told to be quiet, they respond oppositionally rather than positively.

Mr Owens: In terms of the educational system, what kinds of checks and balances would you like to see inserted, whether programmatically or through policy? The children's aid societies presented last week and my question was with respect to accountability: How do we keep kids from getting lost in the school system?

I represent the riding of Scarborough Centre. I'm sure you're more than aware of the issue with respect to the expulsion policy that's in effect. It's my personal view that throwing a child out is just throwing the problem into society, with no program to deal with either the child or the family.

Dr Steinhauer: Mr Owens, you're raising a number of very important questions. At the risk of giving you something more to read, the Sparrow Lake Alliance developed a submission to the Royal Commission on Learning and I would gladly make a copy of that available to the clerk because I think that sums it up much more succinctly than I could.

Mr Owens: I would appreciate that.

The Chair: If you would, Dr Steinhauer, make a copy available to the clerk, then we can ensure that all members of the committee get one.

Dr Steinhauer: Fine. I will send it tomorrow.

The Chair: That's fine.

Mr Randy R. Hope (Chatham-Kent): A couple of the issues that I heard you talk about were ministries working closer together and there was the question asked about the Ministry of the Child which we heard. I'd prefer things to be done more at the local level.

Reading what you have presented in this document and reading the Premier's Council on 2002, its report on the health issues in our society, I am of the opinion that what we need to develop is a human services board and get rid of turf protection of agencies. You know, there are over 7,000 agencies just in the Ministry of Community and Social Services that provide support to communities, yet we're not dealing with the community as a whole.

What is your opinion then about envelope funding per ratio? You hear right now communities are comparing each other and saying, "You get x amount of dollars to service children and we only get x amount." What is your opinion about an envelope funding process and developing a human services board which deals with the global issue?

Dr Steinhauer: In contrast with having each ministry fund its own set of services, until we get envelope funding I think each ministry is going to continue to fund its own services. I think envelope funding is the key to communities getting down and taking responsibility for what goes on, particularly if they're combined with the use of the community report card that the Premier's Council is in the process of developing. I think that might

give some hope that people would realistically look at the priorities.

The one caution I have been given, particularly by consumers from disadvantaged communities, is that they are afraid that because they're not as articulate they may not be able to fight for their rights as well as other communities that are better prepared. I think their feeling is that they're not against the idea of envelope funding, but they are feeling that they're going to need some supports to use it well.

Mr Hope: One of the things that was brought out—and I was listening to some of your conversation, how we get the working family—I mean, when you talk about the issue of quality time aspect, I'm running into that difficulty myself with a young family and being an elected member. They certainly don't rate me by the pay I get, rest assured. Others will say that the pay we receive is not the value.

How do we get communities to really understand the important value when they're dealing with their own lives and their own issues? You brought up the issue about job transition that takes place in today's society. There isn't such a thing as 30 years' seniority any more.

Dr Steinhauer: I think that's one of the reasons that we have set up the Coalition for Children, Families and Communities, to try to keep getting this picture out, to keep saturating the media with the kinds of ways that society is changing, with the needs of children, with the different problems that are coming up and potential solutions.

One of the other things that we hope to do, when we can get some funding for it, is, we want to set up a program of sector advisory groups, where we will take, for example, leaders of a group of seniors, leaders of the business community, leaders of the labour community, leaders of the medical community, the teaching community, the youth communities, the religious community, each of the multicultural communities, and we will get leaders of each of these natural communities looking at the question of "What do you think of what we feel are important for families and, if this makes some sense to you, how do you feel you people can best get this across to your natural community?"

At the same time, one of the things we're thinking of doing, and again this is when we get the funding for it, is approaching the private sector, because we find that (a) we're more likely to get it from the private sector and (b) we're more likely to be free to do what we think is important in the private sector rather than being so tied down that we lose our flexibility.

The other thing we would like to do is run a series of community forums, but rather than just having a one-night forum, we would like to go into that community, establish ties with a group of natural leaders in that community first and have a package of materials that we could send on to them, so that we try to open things up for them and they will carry on from that point.

This plus the saturation of the media is the direction in which we're trying to go.

Ms Jenny Carter (Peterborough): This is really an issue where we're down to the basics of society and I think we're finding from all these hearings that you have

to go back and back to the causes and prevent them.

It seems to me there's still a basic dilemma in our society which women face, which is that if they stay home and are good parents, they're dependent on their husbands. They have no economic existence, and this makes them very weak in the sense that they don't have independence, they're very subject to their husband's whims, if he's the sort of person who has whims. They don't have any status; whereas, if they go out to work, then how are they going to bring up the kids? I think somehow we have to tackle it at that level, because it's partly poverty and it's partly this dilemma that women are in.

1640

Dr Steinhauer: Let me say one thing, and I'm really glad you raised that, because I was trying to condense a larger presentation down. I'm not for a moment suggesting we should go back to the 1940s or 1930s and just tell women to stay home. For a number of reasons, that wouldn't work.

What I'm saying is, I think that men have to take a more important role and I think we have to recognize that if 60%-odd of the parents of preschoolers have all their parents that are in the home working, then we have to have other care giving resources in the community. It doesn't have to be all licensed day care, but we've got to have a series of child care options, as was called for by the Premier's Council, so that kids get good child care, not poor child care.

I think what's happening now is that the families that need good child care the most are often the ones that are least likely to get it. Bad child care, in addition to stressed parenting, is a disaster and we're inflicting that disaster on too many of our children. We can't afford as a society not to get kids good, consistent care giving, and it can't, for a number of reasons, always be because there's a stay-at-home parent.

Mr Owens: On a point of order: I just want to clarify a rumour with Dr Steinhauer. I understand that in the home women do the housework and men help with the housework. Is that true?

Dr Steinhauer: Yes. When women work, women almost always have two jobs. They continue to do the bulk of the housework and the bulk of the child rearing.

Ms Carter: Can I ask you just one single little question about this pink sheet on the basic cognitive needs? It says something about "increased competence in both boys (via increased social responsibility) and girls (via increased social responsiveness)." Why is there a distinction there between boys and girls?

Dr Steinhauer: I don't think we know why that is so. When you look at social competence as it was defined by Diana Baumrind of the University of California at Berkeley, social competence includes both social responsibility, the fact that one pays attention to the rights of others, and increased social responsiveness, the fact that one goes out and gets what one wants and one needs for oneself. All we can say is that the experimental evidence shows that boys and girls respond differently to having informed and attuned parents and care givers.

Mr Owens: Socialization process.

Dr Steinhauer: Yes.

The Chair: I'm sorry, I'm going to have to play the

heavy and step in. Dr Steinhauer, we appreciate very much the time you've taken with us today, and particularly the background material that you've provided us with. We look forward as well to reading the submission to the royal commission. Thank you for coming today.

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

The Chair: We then move on to our next witness, Ms Lucille Roch, assistant deputy minister for children, family and community services in the Ministry of Community and Social Services. Welcome to the committee. I sense someone else is going to join you, and she is most welcome as well. Perhaps you'd just be good enough to identify yourself for Hansard and for the members of the committee.

Ms Nicole Lafrenière-Davis: My name is Nicole Lafrenière-Davis, and I'm director of children's services in the ministry.

The Chair: Bienvenue. We have received a copy of some of the remarks that you're going to make, so please go ahead, and then we'll have time for questions.

Ms Lucille Roch: Thank you very much. We've been following the presentations that have been made to this committee with great interest, obviously, because of our area of interest in the ministry. I guess there was a feeling that many of the issues that were being raised here are issues that we are addressing through the work that we're doing in our children's policy framework, so there was a feeling that it might be a good idea if we came here and summarized the work that we're doing in that policy exercise and maybe give members the opportunity to ask some questions as well. We're quite excited about the work that we're doing and thought we'd like to share with the committee.

I'll basically work through the brief presentation that we've distributed to members, and it's also my understanding that members have received a copy of the children's policy framework. It may have been part of your original package some time ago.

The framework was approved by the ministry last May and was distributed to our stakeholder groups and our area offices. You'll note, for those of you who've had the opportunity to look at it, that the goal of the framework is really to ensure that children and families receive the best possible services from the resources provided under the Child and Family Services Act.

The framework, as you will have noted, sets out six broad policy directions. It talks about the integration of services, better access, local planning, targeting resources to priority groups, the equitable distribution of resources, and quite a focus on accountability, on the benefits to children, youth and families who are actually receiving the services.

I'd like to underline that the framework is not about constraint, but, as I think some of the people who have made presentations to you over the past couple of weeks have noted, constraint to a certain extent, the limited resources available, does put a bit of pressure on all of us to look at what we're doing and how we're offering and delivering services.

The framework is all about making a difference in the lives of children and their families. It's about building a system of supports and services that are centred on

children. It's about building services and supports that work together. It's about fostering healthy development and building on the strengths of children, their families and their communities. I think all of these directions are quite consistent with the recent Premier's Council report, Yours, Mine and Ours, which I'm sure you're all familiar with as well.

We released the framework in 1993, but obviously that was just the beginning of quite a long process. We had to develop clear and implementable policy directives that would support the implementation of this framework. In order to do that, we undertook quite an elaborate process with many of our partners in the children's services area, I think a process which will yield some very good results but a process which, because it included so many people, ended up taking a little longer perhaps than we might have taken had we just proceeded on a ministry basis alone.

We set up a steering committee which included many of the provincial associations I've spoken to you about, including the Ontario Association of Children's Aid Societies, OntChild, the children's mental health centres and many others. We included the Institute for the Prevention of Child Abuse; we included OPSEU and CUPE as well as area office staff. So we had quite a large steering committee.

As well, we established six different working groups to address the six directions that are identified in the policy framework. So we had about 75 people who were directly involved in trying to bring some concreteness to this policy framework. We also set up focus groups of many other groups, including parents and children, ethnoracial groups, francophone groups and children's services coordinating committees.

We've recently put together in one policy document the results of the work of the steering committee and the working groups and have presented a number of recommendations to our minister. These have been approved. The next step will be for us to set up some very clear directives that will go out to our area offices and our stakeholder groups, transfer payment agencies, over the summer. What we wanted to do was kind of highlight for you the kinds of directives that we will be sending out to our transfer payment agencies.

The Chair: Sorry to interrupt, but are those directives public or are those still internal to the ministry?

Ms Roch: At this point in time they're still internal to the ministry.

The Chair: I just wanted to be clear. Just more information that we were going to grab hold of, but we'll wait until it's public.

Ms Roch: The policy directives will set out, I guess, some clear directives to the area offices as well in terms of what we expect from them.

In terms of local planning we want to make it clear that we want our area offices to work with local planning bodies. We want to emphasize the importance that these bodies have as key vehicles for making progress towards integration, access and priorities.

We'll also be very directive in terms of who we think should be involved in the local planning exercises. We want to make sure that parents, youth and community

members are part of every local planning body. In fact, we'll be asking area offices in these bodies to ensure that at least a third of their membership includes consumers, parents and community members.

1650

We want to ensure that all of our CFSA-funded service providers are represented on the local planning groups, as well as bargaining agents. We also want to include child care services. They are funded under the Day Nurseries Act; however, as you've been made aware of by many groups, the early childhood intervention and good child care services are very important in this whole spectrum of services. So we'd like to make sure that they're at the table as well, and of course area office staff.

The other message that we want to reinforce with our area offices as well as our service providers is that they need to involve the other community partners in their communities. They need to involve the schools, they need to involve health services, the police, whoever else in the community is involved in providing services to children.

We're also going to require that individual agencies develop service plans in the context of the community service plan, which will set out local goals to make progress towards an integrated system of services and supports, help focus the resources on children and youth who should receive priority services and use existing resources more effectively and efficiently.

In terms of the meaningful involvement of parents and consumers, we'd like to ensure that parents and youth are involved in the decisions about the services and the supports that they receive, as well as being involved in the planning and the evaluation of the spectrum of services at the agency and the facility level.

I guess one of the things we've learned through our experiences with Better Beginnings, Better Futures is the importance of meaningful involvement of parents and consumers, so I think this is one of the themes that we'd like to reinforce. It's one of the lessons we've learned from Better Beginnings, Better Futures.

In terms of better access, we're going to require that an information and referral mechanism be set up in every community to provide children and their families with current and comprehensive information about the services and the supports available in their communities. A lot of parents tell us they don't really know where to start if they need support, if they need help.

The agencies, I think, have also come to realize that they need to provide some kind of mechanism where people know who to call first. Some communities have set up one-stop telephone services which will link the caller to the necessary and appropriate service. That's being done currently in Kent county and the Northumberland area.

Another thing that we will be requiring is that our agencies set up interagency service responsibility agreements with the other agencies involved in their communities, agreements that set out standards and protocols regarding matters like case management or waiting lists or referrals. These agreements are currently being developed—in fact the Durham Children's Services Council already has such an agreement in place—so that families will not have to shop around, as they have in the past.

Ultimately we're hoping that families, with one person who can help them put a package of services together, will be the way that the services are provided. As people move from one agency to another, as they move from one service to another, they won't be required to keep changing in terms of a case manager. Ultimately we're hoping that families won't have to wait for the services and the supports that they need.

Our directives will also call for the coordination of access to specialized residential services in communities. We've got existing mechanisms that can show us the way in that area. For example, the London Children's Services Network has such a mechanism, and there's also one currently operating in Toronto.

We're also going to be developing a common intake form and a common assessment tool. Some of these tools are already being piloted in the child welfare and children's mental health area. Basically, we'd like to ensure that children and their families don't have to repeat their stories every time they need a different kind of service.

We're also going to require our agencies to provide guidelines for improving access to disadvantaged groups, such as persons with disabilities, lesbian-gay-bisexual youth, persons living in poverty and ethnoracial communities.

In terms of priorities, the directives will require scarce resources to go to those who need them most, particularly children who are the province's legal responsibility; children with serious and chronic needs and their families; and children at high risk. We will require that a range of services and supports be made available for these children, with the emphasis on prevention and early intervention.

We're also going to require agencies to share their resources and their expertise, based on the needs of children and their families. You've had presentations from Better Beginnings, Better Futures, and we also have another program called integrated services for northern children that is already into this mode of making the best use of existing resources.

We're also going to focus on accountability, trying to focus on outcomes. I think agencies are quite interested in demonstrating that the services they provide make a difference to children and their families, and as a ministry we're also very interested in ensuring that the money that's being spent is being spent on services that do help.

We've got a project accountability working group that's working on defining generic client benefits and client outcomes. We're looking at things like personal safety, public safety and enhanced functioning. For each of these three outcomes, we will need to define some more generic indicators, and we're also developing an assessment scale. Hopefully, both of these will be finished by the end of June. We would like to pilot-test these this fiscal year in three different sites in the province, hopefully starting in September.

The other direction that's all part of the policy framework is the funding equity issue. We've got a funding working group that involves associations and service providers which has been developing options for a geographical equity formula.

We've also asked them to develop some implementation strategies along with developing a formula. This is a very important area for a lot of our service providers. It's also a very difficult issue, and we need a fair amount of buy-in and a fair amount of consensus around whatever formula gets implemented, so we've asked them specifically to address the issue of implementation strategies and staging strategies.

Basically, these are the six areas we're working on with our service providers. We see this very much as just a beginning. We're basically looking at changing people's attitudes, changing the way our agencies provide services, and change is always difficult. It's also threatening in many areas.

Having said that, because of the process that we set in place, this quite elaborate process which involved all these people, there is a fair amount of buy-in—I'd say a lot of buy-in—in these directions and the way we're proceeding. I think that was demonstrated at the annual convention of the Ontario Association of Children's Aid Societies, where there was a workshop on the policy framework. There were representatives there from OntChild and the children's mental health centres, who made it very clear that there was, as far as they were concerned, a lot of buy-in among their agencies to pursue these policy directions.

We need to continue, obviously, to develop some of the elements of the directions I've identified. We also need to work with the other ministries to obtain their support and their involvement in terms of service and planning mechanisms. We know there's a lot going on at the local level. We know school boards are sitting down with our child welfare agencies, for example, to support many of these directions. Having said that, at the corporate level I think we perhaps need to catch up to a certain extent on what's going on in some of the local areas.

We also need to do more work around best practices. We need to define what they are and what we need to promote and encourage out there, and we need to identify more effectively what prevention services are, what exists out there and try to translate them into practice.

We believe the implementation of the framework will make a real difference in the lives of children and youth and the families we serve.

1700

Mr Owens: I appreciated your presentation, having had some level of involvement with children's services. I guess it was my entrée into the world of being an MPP when a mom presented herself and her two catastrophically disabled children at my constituency office, needing services. It was then that I discovered the kind of good things that are going on with respect to the consolidation and the one-stop shopping that's happening. Michael Ennis, who is not, I gather, part of your group as such, was extremely helpful in terms of bringing the kinds of services this family needed.

What happens, and what are you doing about it, if a family such as the one I just described moves from Durham to Scarborough? We're not talking about a long trip down the 401. Wire files are not transferred and, as you say, a case manager briefing another case manager because you'd be clearly crossing boundaries—why is it

that people would have to go through the whole reapplication process when basically all they have done is change an address? What are you doing about fixing that kind of crack that families can fall into at a time when they really need to have continuity of service?

Ms Lafrenière-Davis: One of the things we're doing would be under facilitating access. If we do develop a common assessment form, a common intake form, it is to avoid the family having to repeat when she moves to another geographical area.

Mr Owens: That's right. In terms of the kinds of cultural sensitivities that we are quite aware of in the province, how are you going about designing a system that can respond to those kinds of cultural differences so it's not the kind of homogenous or mixed service that's provided, even in Metropolitan Toronto? There's a great variation in what's required with respect to children's services, so what kinds of things are you doing around cultural sensitivities?

Ms Roch: One of the things we've begun to do is engage in some dialogue with our transfer payment agencies about the nature of the province and how it is changing. We're also looking to provide them with some more direction in terms of our expectations around that. We're looking at some directives around ensuring that the boards of directors, for example, of our transfer payment agencies clearly reflect the communities that they represent, that they're part of, and also trying to ensure that staffing at the agency level is also reflective of the community, as well as trying to ensure that the services themselves are sensitive to the needs of their community. That's part of the process. We're not there yet, but that's part of the process that we want to—

Mr Owens: That's part of the goal at the end of the day, the consolidation, the one-stop shopping and sensitivity to various cultural groups.

Ms Roch: Yes.

Mrs O'Neill: Thank you very much for the presentation and bringing us up to date. I have seen one improvement, and I should acknowledge it, in the youth in care. They have been able to finally come together, express their concerns and articulate them. I would hope that they would be used as a model to involve other youth. We have had youth before this committee, and I don't think that with the present government or perhaps parliamentarians in general, they feel they have real contact with the process around Queen's Park.

I have some difficulty with the presentation you've made in that, if you were here earlier, and I think you were, Dr Steinhauer and many others who have come before us have talked about the involvement of other ministries. I still feel that's a weak part of this document.

I have been working on developing children's policy within my own party in the last year. I visited one of the areas that you suggest is a model area, Northumberland, and I feel they have a lot going for them there, but even in my meeting with those I considered the leaders, and there were 15 of them at the meeting, they still told me they have to contact seven to nine different agencies or ministries if they find a child in real difficulty. That is a problem. That was an educator who brought that to me.

I don't know whether you want to respond to that, but

I still think there are weaknesses that perhaps Better Beginnings, Better Futures can lead us out of.

I also wanted to ask you this direct question: Is this model really leaning towards regional funding envelopes? You talk about structures that are regional or community-based. Are you talking about a regional funding envelope as well?

Ms Roch: We're not talking about regional funding envelopes at this point in time, which is not to say that this may not evolve towards that.

I would acknowledge some of the weaknesses you've identified. Our feeling was that we had a number of issues within the services provided in our own ministry that needed to be resolved. We have quite a fragmented system out there and felt we needed to bring it together somewhat. While acknowledging that these directives don't apply directly to Health or to Education, we felt that as a first step we would try and get our own services working perhaps better and more effectively.

Having said that, there are two things I should add. The policy framework makes it very clear, I think, and it's a message that we've reinforced—it's a question I get asked a lot myself when I go out. We've reinforced this notion that they have to be working with their local partners. It's a notion that I have as well reinforced with my own ADM colleagues in Health and Education. We've started to meet again and want to clearly identify some priorities for action over the next year. But clearly our own policy framework initiative has to be very much part of the discussion with the other ministries.

Mrs O'Neill: They have to take some ownership for this.

Ms Roch: Yes, they do.

Ms Lafrenière-Davis: It's important to state that before the policy framework was released for publication, the minister at that time had asked the ministers of the partner ministries, including Health and Education and several others who were at the table at the time, to sign off on the policy framework. So the copy that you have was actually signed off on by our partner ministries before it was released. As we've moved on firming up our policy directives and recommendations, we've gone back to them again recently to share with them what these recommendations now look like concretely, in the form of implementable policy. So again, we're bringing them along with us.

It's important to state as well, and I think the policy framework does mention that and clearly says, that the broad goal is a system of services that's integrated across ministries. This is mentioned in the policy framework. If you were to imagine a road map, what we're saying in the policy framework is that there are some communities that are very close to that goal and are way ahead on that road, and they'll need to continue and we'll do everything to support them. There are others who are quite far back, and we're going to make our directives clear and monitor their progress on the road.

1710

Mrs Dianne Cunningham (London North): I'm looking forward to the next presenter, who is going to be speaking on behalf of the Ontario Association of Children's Mental Health Centres, where she looks at and

refers to the major report of the Premier's Council, Yours, Mine and Ours. I'm wondering where at least three or four of the recommendations that I'm aware of in that report are taken into consideration in this one, in the framework.

Ms Roch: The Premier's Council report puts a lot of emphasis on the integration of services, a lot of emphasis on early prevention and intervention and a lot of emphasis on community involvement. Those are all themes, they're all very much a part of the directions of the children's policy framework, so we see them very much as being very supportive of one another.

As well, the Premier's Council recommendation around developing a report card would be very helpful for our local planning groups in getting a handle on where their own children are at and getting a handle in terms of evaluating the kinds of services they are providing. So we're quite supportive of the council report.

Mrs Cunningham: One of the statements that was made that maybe hasn't been made to the same extent in the past is the role that the community will play in the nurturing and raising of children. In that regard, I'd like you to think about what that really means, because I think it means more than coordination. I think it means direct services to families in some way, some respite, more foster care, those kinds of things. It probably means working very closely with the schools, because all of us heard a presentation from Mr Loughheed last week with regard to the kind of children-at-risk programs they have here in Toronto.

My only other observation is this: You refer to London, which is my city and I've been involved in the services, I suppose, ever since I've been there, for 25 years, and you talk about the one-stop. We started, and I think others on the committee will relate to this, coordinating committees for children and youth 20 years ago, so saying that communities have to work together is not new; it's been a recognition, at least of the agencies I've been involved in, for at least 20 years.

You refer to the London Children's Services Network as such a mechanism to make sure the right child is in the right resource, and yet last week, when I was at the district health council meeting, I think they had just been defined as the one-stop, overriding agency for long-term care, which Mr Owens was asking about, and that long-term care does include children's services, does it not, at this point in time? It's for all services.

Ms Lafrenière-Davis: Long-term care will include children with disabilities, children with chronic needs.

Mrs Cunningham: Okay, except that that is one of the disagreements on behalf of the London community, that those special children, especially children in mental health centres and other services helping kids with disabilities, don't want to be part of that. I'm just leaving that with you, because they don't want to be part of it. They have their own access. They've worked on it, they've established it and they do not need another roadblock to getting their services. They've taken a very strong stand in that regard. I have a number of letters in my office and I think others would be getting the same kind. Maybe you could look at that, because we're talking about children at risk, and if we're talking about

one place to go or make a phone call or whatever, it doesn't have to be the same place you send seniors.

Mr Owens: That's the purpose of the multi-service agency, particularly—

Mrs Cunningham: It doesn't matter. It's just words to these people—

Mr Owens: I know it doesn't matter, but "Don't confuse me with facts," Is that what you're saying?

Mrs Cunningham: —but I'm just putting it as a complaint. I think it should be dealt with specifically in the framework.

Mr Hope: Just check out the Kent county model, Dianne. You'll find a good one there.

Mrs Cunningham: I'll tell you one thing, and I think all of us would agree here, there are models that work across the province, but they change, in my view, with regard to not only the kinds of children's special needs, but they also change with the people who are doing the work, the front-line workers and the dedication. Without them, it doesn't matter what you put on paper, nothing's going to happen.

What we need is accountability in the system. Where services are really being provided and people are doing a good job, we should be rewarding them, and where they're not, we should send them somewhere else where they can be useful. There are a lot of communities where people are paid to do the work and they could be doing a much better job, but we have so little accountability in the system.

If I had to underline anything that was missing in this, it's the accountability part. If I had your job, I'd be moving very quickly on that one now, because there are far too many agencies that take on far too many families, huge case loads, and they could deliver their services in a very different way, even given the system we have now.

Ms Roch: One of the areas we hope to be piloting in September is the whole area of accountability.

Mrs Cunningham: I would say make the pilot project very short and very sweet.

The Chair: I regret that we're at that point where we've run out of time. Can I just ask for one clarification, as we go forward and get to working on a report? Firstly, on page 4, when you were talking about the recommendations made to the minister—then those are going to be worked on with the areas. I take it, though, that what you have generally described fits in with that approach so that we can, as a committee, assume that those are the general directions that are being provided.

Ms Roch: Yes.

The Chair: Secondly, when you are making reference to a local planning body that would be set up, are you thinking here of something that is new? Is this similar to a multiservice agency in long-term care, or is this bringing together existing bodies?

Ms Roch: Many communities already have local planning bodies. Ms Cunningham pointed out that in her community it has been active for over 20 years. Other communities don't have them and we need to set them up. We don't want to reinvent the wheel; we don't want to fix something if it isn't broken either.

The Chair: Thank you both very much for coming to the committee this afternoon.

ONTARIO ASSOCIATION
OF CHILDREN'S MENTAL HEALTH CENTRES
C.M. HINCKS TREATMENT CENTRE

The Chair: I call our final witness for this afternoon, Dr Freda Martin, who is the executive director of the C.M. Hincks Treatment Centre here in Toronto. Dr Martin, I believe you're here both in your capacity I've just named, but also representing the Ontario Association of Children's Mental Health Centres. Is that fair?

Dr Freda Martin: Yes, thank you. I principally represent the Ontario Association of Children's Mental Health Centres.

As the last speaker of the day, I'm assuming that over the course of your hearings, although I haven't heard them, you'll have heard very ample evidence from those much more competent than I am about a variety of sociological and epidemiological factors and the changing nature of society and the increasing risk factors, so I won't really focus on those at all, without meaning not to agree or to support those. Because I represent children's mental health, I'm going to focus narrowly down on that area and try to talk with you a little bit about why those of us working in the field are becoming increasingly more concerned.

I hope it's worthwhile to give you some background information, because it's our perception in the field that children's mental health isn't well known or understood. Hopefully, I'm not wasting your time in just giving you some background.

In 1992-93, all of the centres together served about 66,000 children and their families and employed about 4,600 staff. Children come to our centres at every age, from a couple of months to the end of the time at 18 years, and because of a very wide range of problems. A few of those are inborn, but most, the big majority, of them are heavily influenced by the environment: the family, the school, the early nurturing those children receive.

They include everything from failure to thrive in newborns, excessive crying, difficulties in sleeping, to the ones you're probably more familiar with in school age: problems with language and other developmental difficulties, violent and disruptive behaviours, school achievement falling way below potential and children with very excessive anxiety, which really interferes with their academic and social life. In adolescence, we see all of those, plus the beginning of the major mental illnesses: depression with suicidal tendencies, schizophrenia.

The C.M. Hincks Treatment Centre where I work is perhaps a good example of one of the larger centres. We offer a pretty full range of service. We have two long-term residential units serving the most severely disturbed adolescents, and perhaps in the province are the only places that offer long-term psychiatric treatment for youngsters with severe disturbance. One of those is located on a 100-acre working farm in the Collingwood area. The kids actually run the farm, and that's part of their rehabilitation.

1720

Just as an aside, because I was interested in your question about long-term care, somehow we wouldn't

really feel included in that district health council long-term care. We haven't been consulted; there have been no representatives from us on that. The district health council really doesn't seem to think that children's mental health is part of their mandate and we're hardly represented on it at all. That's really just an aside because I was interested in your question.

At the other end of the spectrum, coming back to the Hincks, like many centres, we've recently deployed about 10% of our outpatient budget and created something we're really very excited about, which is a model early intervention prevention program for all children under the age of five in the neighbouring very high-risk area of St James Town.

This program is a collaborative one between ourselves, the city of Toronto public health department, which has seconded a number of nurses to us, and the Board of Education for the City of Toronto with its parenting programs in the Cabbagetown Youth Centre. Our objective is to visit, assess and offer a range of services to every child and their parents who are born in that area. The services will be a full range and they'll be onsite, everything from a paediatric developmental clinic to a range of parenting groups, child-rearing groups and a community advisory board.

At the site on Jarvis Street, we offer the usual full range of individual, family and group therapies, day treatment programs, some onsite and some in the school. We are a university unit and have a lot of input into training and research.

Because of the emphasis on residential programming, you need to be aware, though, that across the province only 5% of the children the association serves are in residential programs. The vast majority are in community-based programs.

I guess it's also not news to you that the demand for help far outweighs the availability of services. Although most agencies have made major changes in an effort to reduce or eliminate waiting lists, the association's surveys continue to document that as many as 7,000 children are waiting for services across all the centres.

This really regrettable situation is no surprise when you think of the Ontario Child Health Study statistics that 18% of all school children suffer from a psychiatric disturbance, and of these only one in six receives any form of help. So that's a situation in which it's unlikely there won't be a lot of people waiting for help; 18% of all our children is a large number to have a diagnosable psychiatric disturbance. I'll be coming back to that in a minute.

In that situation, and I again was interested in the comment of the need for integration across ministries, because I think nowhere more than in children's mental health do we experience that fragmentation.

First of all, children's mental health is not a priority—it's not a mandate, in a sense—for any ministry of the Ontario government, and I think it's always in danger of falling between the cracks. Education is currently reducing its support for special-needs children. Health overtly takes no responsibility for children's mental health,

although it does fund some 20-odd centres across the province which are physically located within hospitals.

The Ministry of Community and Social Services designates itself as the lead ministry. However, in today's fiscal restraints, they make it clear that mental health falls into a non-mandated or discretionary category of service. That, in a sense, makes children's mental health a very different priority from physical health, because it's not mandated by anybody.

In the current economic environment there is, of course, concern that everyone is focusing on their highest priorities, and this creates concerns for children's mental health centres. As an aside, I guess I think it's a much bigger concern for society than for individual centres.

This brings me to the main point of my evidence. You're probably fully aware of the kind of cycle of risk that goes on, and I'll come back to it. In summary, the points that I want to make today are that, first of all, I think we have to face that children's mental health is deteriorating to the point where it's not dramatic to talk about a crisis, and that this situation matters profoundly to all of us because of its effect on both our social fabric and on our economic development.

The other point I would like to make is that we do actually have the necessary knowledge. We know what children need for healthy development as much as we know what they need for healthy physical development, and we know the essentials of effective intervention programs. But there is an enormous gap between that knowledge and current social policy; between what we know and what we do. The recently published Carnegie Corp report makes that point very strongly, that there's a big gap between knowledge and social policy.

To come to the end at this point, our association would want to make to you two basic recommendations: one, to underline that we strongly support the work and the recommendations of the recent report of the Child and Youth Project Steering Committee of the Premier's Council, Yours, Mine and Ours. If any of you have not had an opportunity to have a look at that, I strongly recommend it to you. At least read the summary.

The other thing we'd want to say is that these recommendations shouldn't be carried out at the expense of current treatment and intervention programs.

To expand a bit and to underline the point, because I think we have to think about public awareness and where we're going to put dollars, it's true that physical health has improved in the last 30 years in our country. Nevertheless, children's emotional wellbeing has deteriorated. For example, infant mortality rates have dropped from 40 per 1,000 infants to seven in the last 30 years, and life expectancy has increased. So in terms of physical health, we're supporting children reasonably well. But the incidence of emotional disturbance has increased quite significantly during that time when physical health has been improving.

The most authoritative study, by Professor Michael Rutter, in 1970 would have indicated an incidence of emotional disturbance of about 4% to 10%. The Ontario Child Health Study in 1986 was documenting 18%. A

couple of more recent studies in the 1990s: a study that studied every single child from zero to four in the small town of Brockville documents something like 23% of three-year-olds whose parents or teachers or day care workers were seriously concerned with their difficulties in managing aggression; and a very similar study by the Canadian Institute of Advanced Research in Montreal has documented something like 26% of seriously aggressive four-year-old boys. We also know that those same boys will then be at risk for dropping out of school. If you're documented at that level, then the chances that you will drop out of school before you're 13 or 14 are high.

We know aggression is something you don't grow out of. Of all the characteristics, apart from your IQ, your tendency for aggression is the most stable. If you measure it across the lifespan, this is not something we can afford to take lightly.

Suicides in youth have increased threefold in this last 30-year period. Our functional illiteracy rate stands at 20%.

I want to put to you that if I gave you those sorts of figures in relation to a serious physical illness, we'd be talking about a tragic epidemic and there would be a real cause for immediate action. Certainly they point to a public health problem. The recently published Carnegie Corp report refers to it as a "quiet crisis."

Sometimes—I didn't really mean to say this, but I will—when I really get going, I say, "You know, in emotional health we have a public health problem that is about comparable to the one we had in physical health at the turn of the century." And we know how to do differently. What I mean is, emotionally we don't pasteurize the milk, we don't clean up the water, we don't ensure adequate nutrition, and then we wonder why we've got problems. But we could do those things. We really could. We know how. I guess my feeling is, we need to, because this is getting out of hand.

So the next point comes: It matters. I referred you to the two major reports that have just come out this month, the report of the Premier's Council and the report of the Carnegie Corp of New York, *Starting Points*. If you can get a look at that one, it's worth looking at too.

These two major reports are in substantial agreement. Both of them point to the seriousness of the situation. Both point to the importance of facilitating emotional and cognitive development in the first four years of life. Both agree that the research evidence is now conclusive: that much more than we used to think, those neuronal connections are laid down in the brain during that first three years and you're wired, just as much as your bones are developed with calcium and your lungs function and your heart functions. These connections determine to a large extent creativity, capacity for industry, capacity to take initiative and probably long-term affectional relations. In addition, these connections are largely environmentally determined. You're not born like that; it depends what kind of stimulation you receive, what kind of neuronal connections are laid down. It's too bad that we have to wait for the physio-neurologist to scare us to what was open to anyone's eyes to see, but anyway, the neurological evidence is in.

1730

Maybe I won't, to save time, tell you what children basically need, unless you want to hear it. You can read it. We know the basic ingredients, and I've summarized them there for you.

I might make some comments as to why we think this has really reached a kind of crisis proportion. But before that, just a comment that when we talk about risk factors—poverty, single-parent families, women working—I think it's important to look at what the pathways are. Those things aren't in and of themselves bad, and I think in our country in fact it's rare for physical poverty to be a cause of a problem. Otherwise, we'd see infant mortality rates increasing and we wouldn't see us living longer. The point is that those things go along with and underpin chaotic living conditions: children who then get broken relationships, who get moved about from pillar to post and don't have the opportunity for one of the basic things they need, which is to form long-term, continuous, supported relationships with one or two people. So it's because of the things they do.

It's also because parents who are poor often give their children a sense of helplessness and hopelessness. Those parents themselves feel hopeless and ineffective so they cannot impart to their children the necessary experiences that make a three-year-old feel effective.

So there are clear pathways, and I think the more you understand the pathways, the more you can think of what would be effective to do to change that. At some point, other people may want to give you more, but I think that kind of stuff is in, and we know what needs to happen.

So why have we gotten into this difficult place? First of all, I think mental health has never been a public priority nearly as much as physical health or technological advances. We just don't spend 1/100 of the money on it. Emotional health has been seen perhaps to be almost more of a private, almost kind of a moral matter, and only recently is the hard information available to tell us that this is a mistake.

As I think Dr Steinhauer was saying, the recent changes in society—poverty, the role of women and so on—mean that, increasingly, individual parents and families cannot provide what their children need by themselves.

Second to that, we're making increasing demands on our emotional well-being and adaptability. Society now requires not a lesser degree of emotional health, but more. We have a rapidly changing pace, diverse cultures, we need longer learning. We know that in the next generation, with the information age, the human brain is going to be our greatest natural resource, not fossil fuels, so if we don't do something about it, we'll end up economically very disadvantaged.

There's a third factor that you're probably aware of as well: Our increased technological capacity means that we have a greater power to destroy things and do damage. So if you're an angry, impulse-ridden, somewhat self-centred person and in your culture at school things aren't settled by fists but by knives and guns or bombs, you can just wreak a lot more havoc than you used to be able to. I'm

not sure if children are more angry than they used to be, but they certainly have a greater scope to express that. We need to think about how to help them with that.

So you put all those three things together—decreased ability to give nurturance, increased need for flexible and creative individuals and increased capacity for destruction—and you've got a real explosive mix.

That brings me just finally to my recommendations. The association has voted, as I said, to strongly support the Yours, Mine and Ours document: that we take a population-based public health approach; that we emphasize prevention and emphasize the early years; that we do need objective outcomes, we need to document how our children are doing. We certainly support the need for the report cards on achievements outlined in page 61 of that report and we certainly support the recommendation for a province-wide community mobilization campaign and active support for the development of a range of programs created by and specific to each community. Children's mental health centres would certainly expect to be active partners in this process.

However, our second recommendation would be that this shouldn't be achieved simply at the expense of current treatment intervention programs, because of fiscal restraint, and that's because we do believe that many, if not most, of those programs—even the ones at the Hincks, which are probably among the mid-range of expense for residential treatment—play an essential role in damage control or in containment of the problem.

These children and youth aren't going to disappear; they're going to remain, rather like the carriers of germs in an epidemic, a source of contagion, and I believe by their non-productive and often violent and anti-social behaviour they would cost the country very much more untreated than treated. That is, if they're just let go, the cost to the welfare and the penal system and perpetuating this risk will cost more than the year's treatment they might need to have.

One thing I'd like to emphasize is that although I believe that, I don't absolutely know it, and that's because we haven't really had sufficient support to do proper outcome studies. Coming back to the report cards, that's one thing we really do need. I can say that I believe we prevent more in prison sentences and in welfare and in helping these kids to earn money rather than to be a drain on it, but I don't 100% know it.

One of the reasons I bring this to you as a policy thing is that one of the most difficult things technically about it, or subjectively, is that you need to be able to track these kids for five or 10 years to demonstrate that, and for that we need some policy that would encourage them to stay in touch with us. We've been trying to mount this at the Hincks for some time with some success, but our biggest problem is that we lose the kids and we can't keep track of them.

I'd like to see some policies that would say to children and their families when they come into these expensive programs, "One of the things we expect you to do is stay in touch." It may be as simple as that, because otherwise I don't think it would be that difficult. We're not looking at sophisticated research outcomes; what I only want to

know is, have you got a job, did you stay out of prison, did you complete school? I mean, they're pretty concrete things that would give us those kinds of results.

I also don't think it makes much sense, and there's a bit of concern in the MCSS policy directives that the last presenter gave to you stopped treating the middle group of children, because they're the ones we can treat. So to say, "Well, we'll put everything into prevention and we have to treat these high-risk kids, so the middle group of children with the ordinary run of children's mental health problems, we won't treat them until they get so serious that we have to," that doesn't make any sense. Most of those children can be treated and turned around very inexpensively, and it also discriminates against mental health in relation to physical health.

The Chair: Thank you very much for your presentation, and we'll move to questions. I just note for your own information that the committee did spend a day with the Premier's Council—

Dr Freda Martin: Oh, good.

The Chair: —and they presented their report to us. The other report that you mention, the Carnegie Corp, I think would be useful for members to get a copy of that, so perhaps we can get the reference for that.

Dr Freda Martin: What I could do is, I have it. It's hard to get from New York; it takes a bit of time. Since I have it, I could have a copy sent over to you and then maybe you can just have copies made.

1740

Mr Tony Martin (Sault Ste Marie): Thank you for a very interesting and worthwhile brief. As I sit through these hearings and hear people come forward and listen to the presentation of the Premier's Council and others, one thing that kind of jumps out at me that I'd like to know a little bit more about, because it doesn't necessarily jibe with my experience and understanding of some of the mental health challenges of communities, is the question of the contribution that poverty makes to this whole question. The assumption is that poverty is one of the significant factors in it all, yet I know of families who were poor who didn't have mental health problems. In fact, they were some of the healthier families in communities that I lived in, and kids from those families went on to do some really tremendously wonderful things with their lives.

In some of the work that I've done before I got to this place, as I tried to get a handle on what was happening in the community re the mental health of the kids whom I was dealing with, there was no consistent stratum of people who came into my area with difficulties. They came from all walks of life, and the reasons were myriad as to why they ended up in difficulty with the law, doing drugs or having difficulty with their parents.

The question I would like to explore with you a little bit further is this whole question of poverty and your response to some of my comments. The other is how we get the community more involved in this whole question, because I get the feeling that we've abdicated responsibility to professionals, who can't do it by themselves.

Dr Freda Martin: Absolutely.

Mr Martin: Until we get everybody together around this and we all begin to take some responsibility, we won't resolve it. Again, in my previous life and since I've been here, we talk about needing to bring people together around these questions, needing to be working more collaboratively, yet we seem never to be able to get there. What, in your mind, is the major obstacle?

Dr Freda Martin: Let me talk about poverty first. I'm glad you raise that because I agree with you. I know lots of very poor who are perfectly healthy, and we see very many children from good working-class families, as it were, and in the middle classes and in the well-to-do who are very unhealthy kids. Poverty in and of itself does not cause mental ill health. It has been associated as a risk factor. I think it's sometimes not noticed, because people are concerned about poverty, that in the Ontario Child Health Study poverty in and of itself was not a risk factor. What was a risk factor was living in subsidized housing. That's a different thing, and it starts to point you in the direction of what I was talking about, that it is chaotic parenting which is associated with poverty but not just with poverty; parents who themselves feel hopeless and ineffective and somewhat outside of society, not valued and not contributing, who then create the kinds of conditions in the first five or six years of life which are not healthy for children.

But it isn't not having enough to eat or enough to wear or a roof over your head that is the issue in this province. The issue is to have parents and communities who feel active and something they can do about it and effective and to have the stability, particularly of relationships in the very early years, for children.

I was just looking at another study which you might like to look at called *Staying on Track*, which is just out. It is also a report of the Premier's Council and is the study of all these children in Brockville who were looked at over the five years of their life. In that study, which looks only at younger children—the Ontario Child Health Study starts with school-age children—from birth to age five, poverty did not emerge as a risk factor, so we challenge the literature on that a little bit. Mothers' depression, mothers' perception of children, mothers' relationship with children and mothers' level of education were much greater factors than poverty. It doesn't mean I think we don't have to deal with poverty.

The Chair: Mr Martin, I apologize. We are going to be called to the House for a vote and both Ms Cunningham and Ms O'Neill have questions, so we'll just have to move on to Ms Cunningham.

Mrs Cunningham: I'll move quickly because I'm sure that others or my colleague will want to speak to Dr Martin. I'm thrilled with your presentation. I think we've all been privileged this afternoon to hear from you, and I was looking forward to it.

The first point you made on the district health council was brought to me as a concern, so I'm glad I was able to at least get it on the record. We'll deal with the Ministry of Health, but I think through the Ministry of Community and Social Services. They ought to know about the concern.

But the other point, and I appreciated the question

from Mr Martin, is with regard to how families alone cannot provide what their children need, and the points that you've just made: How do you get the community involved? There are many agencies and professionals and families and schools that have tried to get the community involved across Ontario who have had some success, and others who haven't. My observation is that we should be looking at success stories and maybe model them.

But my third question has to do with something that's close to my own heart, where you said about tracking children. I can remember working in Merrymount Children's Centre in London, Ontario, which wasn't a treatment centre but did a lot of the kinds of work that are needed to keep families together. When people wanted to work there for me, social workers, I said, "Be prepared to work with the same family for five years." We had great success. We watched the mothers gain in confidence and the children be more successful at school, and two or three of us have followed those children for 15 years.

For me personally—it was just my own little idea—it seemed to make sense. I have no idea why that isn't followed around the province, instead of case loads where the mothers are referred to different social workers and different case workers on almost a weekly basis in some instances.

Dr Freda Martin: There's no doubt continuity of relationship with the care giver is really important. In bringing it back to your point, I agree with you; I think parents alone can't do it any more. But no one ever thought they could, you know. That's a kind of aberration of the last 25 years to think that parents alone can.

Mrs Cunningham: You're right.

Dr Freda Martin: It takes a whole community to bring up a child. Professionals certainly can't do it, and I'm not advocating at all that more money be put into the health treatment system, mental health or any other. We know there's a big difference between the health of the population and the health care system, that those two are somewhat separate in the things that influence them. I'm really tied much more to a public health system, and for us that means a different social community connectedness.

I think we can get together parents, professionals, schools, communities, and join them into a much more connected network, which is what children need. They don't need to grow up in isolated communities where their parents hardly know the people on the street and are stressed out, if you think of the kind of network of support that a child needs. I think we can do that.

There are model programs we can look at. Staying on Track is interesting because it also was a collaboration with the public health nurse. The cost of it was something like \$450 per child per annum and it was shown to be quite effective as an intervention as well as a tracking. I think 90% of the parents who were in that said they would have liked to stay in it and that it should become a permanent part of our delivery system. It's kind of the same as a kid having paediatric checks. Their parents were checked and they got information as to where their kid was, and those who were seen to be seriously at risk

were referred to somewhat more specialized resources. But that's at 18 months and two years of age, and that's when it needs to happen. I think we can do those things. It isn't that we don't know what to do any more. We didn't maybe 10 years ago, but we sure do now.

Mrs Cunningham: What about the informal programs as opposed to formal? I guess I could give you a couple of examples. We see so many children now, in my view, who are totally rushed. At least six days and maybe nights a week they're rushed from one organized event to another. You used the word "chaotic" parenting. I think that was the word; it's a good one. So we have that.

On the other hand, we have preschool programs in our educational institutions, but because it's so expensive, we have rural boards sending kids on buses—and some of them are three years old—every second day, that kind of thing. I'm not saying it's good or bad. It seems to me, though, that we don't often think about practical programs that can help parents and children work through life together. We seem, through our programs, to make it more difficult for parents.

1750

Dr Freda Martin: I can only agree with that. I think networks of local rural families—there are some local rural child care centres set up that way, as home-family based—could make a lot more sense. Probably we need to offer a lot of range of alternatives to people, because not everything suits everybody.

Mrs O'Neill: I thank you very much for coming. It's a very good closure to our study, Dr Martin. I think you said some things that I've believed for an awful long time. Maybe you didn't say them in these words. I think mental health has always been taken for granted. Whether it's our own mental health or those around ourselves or those whom we work with, we tend to have taken it for granted. At least through my lifetime, that's been my experience.

Although you didn't read it into the record, I was very happy to see that you talked about expectations for children and that high expectations do have an effect on children. I think we tend to forget that sometimes. I think you talk about parents as models of self-control also being a very important component of the family structure. Both of those things aren't talked about very much any more.

I'm quite interested in what you hit on technology, because you seem to be the only one who's mentioned that effect, the effect of technology on the home. As I mentioned earlier, I have been working on children's services quite a bit this particular year. When we met with young people, and I'm talking now about 14-, 15- and 16-year-olds, some of them said to us, and I think they were being very realistic, "There's so much TV in our house now, so many people involved in video games, computer games, nobody talks to each other any more." That really hit me between the eyes, to think that would be something they would feel important enough to present when they had an opportunity to present almost anything.

I like the best-case scenarios. I just wonder if you

could close off by telling us a little bit about what must be a success story in St James Town where you're working. You're talking about a developmental clinic and home visits. Could you tell us a little bit about what that's about and why it's successful?

Dr Freda Martin: It's really only just starting. We're very excited about it, partly because Dr Sarah Landy, who did the Brockville study, is working full-time there and we've been able to get her. It is using what we know about what works, the model of prevention, to mobilize the community, to put together the experienced expertise of someone like Dr Landy with Cabbagetown Youth Centre, which is the local resource, and with public health and education.

We've been able to get premises there, which is an exciting story in itself, right in St James Town, located under the Dominion store at 240 Wellesley, I guess it is, where it will be one-stop shopping.

Initially, we'll get a birth notice for every child who is born. They'll be visited. A good contact will be made. We're particularly interested in reaching the kind of single parent who doesn't come out of her apartment normally. We will involve a range of ethnic cultures in the home visitors so that people are visited if at all possible by someone of their own culture. We've got maybe half a dozen different major cultures we have to work with there to talk with them about what they would like to do.

There'll be a whole range of groups that parents can join, some specifically working with difficulties with aggressives, some just discussing parenting techniques, some more socializing, some mixtures. We'll have a smorgasbord of things that people can go to in a local community centre, involving local women as much as possible.

With that, and what I think makes it exciting, is that we have the children's mental health people working right there on site. We're attracting an exciting range of volunteers. Some of them are community volunteers. Some of them are university students, particularly MA psychologists. The deal with them is that they can do

their PhD and we'll give them a nice piece of work to do and some supervision and they'll give two days a week of counselling and training time. Actually, we've got more people than we know what to do with at the moment in terms of hands to do the labour.

There was a very interesting thing that happened. I don't know if you saw in the paper that the Sterling Foundation came up—they're a foundation modelled on Jimmy Carter's project that refurbishes and redoes places—there were actually 800 people registered at the local school in St James Town, about half of them from part of the Sterling Foundation and half of them were local people. They all spent Saturday and Sunday together, putting that community place in shape, like scraping the paint—I was there too—and painting and doing wiring, because we had this derelict set of rooms in the bottom of St James Town that had been put there but never been used. They were meant to be a community centre and the space was there.

The hope was, and the belief is, that now—we had Tamils and Vietnamese and people like me and Spiro, who's Greek, who's head of Cabbagetown Youth Centre—that way we'd get community participation because those people now know how to maintain that place and it's there. It's kind of a neat project.

What I like about it is it puts together the highest level of professional expertise in someone like Dr Landy with the whole community development piece. Hopefully it'll take shape.

The Chair: That perhaps is a good positive note on which to end. Dr. Martin, you are our last witness for these hearings. Thank you very much for coming.

We have 12 hours and I would just say to committee members that we have a little less than an hour left which we'll need to reserve to carry out our final deliberations and approve our report. I hear the bells ringing and we're going to have to go up to the House for a vote.

On Monday we begin our hearings into Bill 85, An Act to prevent unjust enrichment through the Proceeds of Crime.

The committee adjourned at 1757.

CONTENTS

Tuesday 7 June 1994

Children at risk	S-1579
Sparrow Lake Alliance; Coalition for Children, Families and Communities	S-1579
Dr Paul Steinhauer, chair, SLA steering committee and chair, CCFC	
Ministry of Community and Social Services	S-1586
Lucille Roch, assistant deputy minister, children, family and community services	
Nicole Lafrenière-Davis, director, children's services	
Ontario Association of Children's Mental Health Centres; C.M. Hincks Treatment Centre	S-1591
Dr Freda Martin, association representative and executive director, treatment centre	

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- ***Chair / Président:** Beer, Charles (York-Mackenzie L)
- ***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Faldimond L)
- *Carter, Jenny (Peterborough ND)
- *Cunningham, Dianne (London North/-Nord PC)
- *Hope, Randy R. (Chatham-Kent ND)
- *Martin, Tony (Sault Ste Marie ND)
- McGuinty, Dalton (Ottawa South/-Sud L)
- *O'Connor, Larry (Durham-York ND)
- *O'Neill, Yvonne (Ottawa-Rideau L)
- *Owens, Stephen (Scarborough Centre ND)
- Rizzo, Tony (Oakwood ND)
- Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

MacKinnon, Ellen (Lambton ND) for Mr O'Connor

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Gardner, Dr Bob, assistant director, Legislative Research Service

C A 2 C N
XC12
- 577



S-57

S-57

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Tuesday 21 June 1994

Journal des débats (Hansard)

Mardi 21 juin 1994

Standing committee on
social development

Comité permanent des
affaires sociales

Draft report
Children at risk

Rapport préliminaire
Enfants en situation de risque

Chair: Charles Beer
Clerk: Doug Arnott



Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Tuesday 21 June 1994

Mardi 21 juin 1994

The committee met at 1602 in room 151.

DRAFT REPORT

CHILDREN AT RISK

The Chair (Mr Charles Beer): Good afternoon, ladies and gentlemen. For today's session, we're going to be finalizing the report of the committee on the standing order 125 on children "at risk."

What I would propose that we do, and we all have a copy of the report in front of us, is again to note, because we do have people watching, what this standing order was about and then read the conclusions and recommendations, after which I would ask the two critics and a member of the government to make any comments they would like to make. Then we will vote on the report.

Just so everyone recalls, the standing committee on social development held hearings in May and June under standing order 125 on an issue designated by Mrs O'Neill (Ottawa-Rideau). What we were looking at was the following:

"To investigate the protection of children, specifically those 'at risk,'" with a focus on "the services available to them and their families, and recommendations to improve the continuum of services, from preventive programs to agencies of last resort. By 'children at risk,' the committee means: children in need of protection under the Child and Family Services Act; children affected by inadequate living conditions and child poverty; and children suffering physical and sexual abuse."

As members can see, the document itself numbers a number of pages. I think there's an excellent summary of all the testimony that came before us. I will just read the last three or four pages, which contain the specific conclusions and recommendations.

"Conclusions and Recommendations"

"We heard from witness after witness that both the conditions that place children at risk and the types of programs and services that can protect children and prevent "at risk" situations are well known. Service providers, advocates, experts and youth stressed that there has been enough study and consultation; that now is the time to act. We also heard of many innovative services and programs from across the province that indicate promising directions for the required action.

"There are two directions that we want to highlight: the need to prioritize programs and services that can prevent child abuse, neglect and poverty and the need to more effectively coordinate and integrate services at the local level. And, of course, these programs need stable and predictable funding to be able to plan their services."

"Toward a Preventive Approach"

"The evidence we heard was overwhelmingly clear:

—"The conditions that place children at risk, such as poverty, the pressures on single and isolated parents, lack of education about parenting, lack of community support services, limited access to child care or respite care etc are well known.

—"Situations in which children are particularly vulnerable can be identified.

—"A wide range of innovative programs have been established to address these conditions.

—"Their benefits have been clearly demonstrated, both in terms of effectively improving children's immediate conditions and prospects and of preventing more extensive and expensive later intervention.

—"These programs are inadequately funded and there is little clear policy direction from federal, provincial, municipal or regional governments to support such preventive approaches.

—"As a result, the development of preventive programs has been inconsistent and unstable, and such programs are not equitably available across the province.

"The committee was heartened and impressed by the efforts in many Ontario communities to establish effective community-based preventive projects. Many of the innovative features of these projects showed incredibly promising directions towards which the service sector could be moving. Some, such as Better Beginnings, Better Futures, show the possibilities of strengthening neighbourhoods in the process of caring for children. Others, such as various projects sponsored by children's aid societies and children's hospitals, show the potential of partnerships between education, health, child welfare and other sectors in particular communities. And, of course, such preventive programs are far better for children's quality of life and future opportunities.

"In addition to their long-term benefits, we heard that preventive programs can save money here and now. We would emphasize the evidence presented by two children's aid societies of the considerable savings they were able to realize through programs that prevented children from having to be taken into care.

"We all talk of the 'bottom line' these days; the payoff from investment in well-planned and coordinated preventive programs is immediate and substantial. Governments, agencies and service providers must take a far-sighted approach here. Not moving decisively to facilitate and fund preventive programs and services can only be seen as enormously wasteful and short-sighted.

"The committee therefore recommends that:

"1. Programs geared to the prevention of child abuse, neglect and poverty must be a high priority for government funding.

"The goal of public policy should be to ensure that preventive programs are an integral component of the network of children's mental health services, family support, child protection and welfare, parental education and counselling, prenatal care and other vital children's services in every community. We were pleased to hear from representatives of the Ministry of Community and Social Services that their policy framework will be prioritizing prevention and early intervention.

"But we also recognize that critical barriers stand in the way of communities being able to provide the kinds of preventive services that children and their families need. One of the most important is the policy, funding and legislative frameworks that govern children's services. Which agencies have the mandate for preventive programs? Are some agencies restricted from providing preventive programs even where they may be the most appropriate group in the particular community to do so?

"One example from our hearings concerns children's aid societies. Are CASs to be seen as focusing only on narrowly defined child protection, or should their role also include comprehensive preventive services? We agree with the Ontario Association of Children's Aid Societies that 'the mandate that restricts children's aid societies solely to intervening with the highest-risk families at the latest possible moment is the most expensive and least effective service delivery model for child welfare.' Even if agencies' mandates allow it, many do not receive explicit funding to provide preventive services and have to scramble to cover prevention out of their other programs' budgets or find alternative sources for additional resources. We also heard considerable concern that preventive programs are especially vulnerable when funding is tight or being cut back.

"The province must act decisively to remove barriers within its own policy and legislation. We recommend that:

"2. The Ministry of Community and Social Services, in conjunction with other relevant ministries, identify and remove legislative and policy barriers that curtail children's services agencies' ability to provide preventive programs and services where appropriate.

1610

"3. The Ministry of Community and Social Services, in conjunction with other relevant ministries, ensure that the mandates of children's services agencies clearly allow them to provide preventive programs when they and local communities consider it appropriate.

"A second critical barrier to the development of comprehensive preventive programs is the lack of coordination among children's services agencies.

"Toward an Integrated and Coordinated Approach

"Lack of coordination is not merely a barrier to the development of preventive programs, but limits the effectiveness of the whole spectrum of children's services. While our 12 hours of hearings were only able to

scratch the surface of the complex basis of children at risk, we did see several very troubling directions. With expenditure constraint and program reductions, the fragmentation of the service delivery system is getting worse and the gaps are getting broader. The 'cracks' for children at risk to fall into are getting wider and deeper.

"Again, witnesses presented very clear evidence of the problems of the existing system of children's services:

"The children's services system is a patchwork in which agencies and programs have evolved in a haphazard and unplanned fashion;

"There are no institutions with the mandate or resources to coordinate local services and ensure that the full spectrum of vital services is available in every community;

"One result is that there is both considerable duplication in services provided by different agencies and significant gaps where no one is meeting a pressing need;

"A second result is that access to services varies considerably from community to community;

"Funding can be incredibly complex, with particular programs and agencies funded by ever-changing combinations of ministries and levels of governments;

"No agency or institution has responsibility for case management or the coordination of services for particular children and their families;

"Intake, evaluation and management vary a great deal between agencies—as a result, the nature of the care a child receives can vary tremendously depending upon where they entered the system; and

"It can be daunting to work through the maze of service providers, each with their own bureaucratic structures and rules, to find appropriate services for children and their families. This task can seem particularly overwhelming to parents who cannot get help in negotiating the system.

"The committee feels that the current fragmentation of services is an impediment to helping Ontario's children at risk. That a child in difficulty must deal with many different agencies under the auspices of several ministries is unnecessarily time-consuming, confusing and costly.

"We are also greatly concerned that in the current climate of restraint various institutions and ministries appear to be cutting back programs in an unplanned way. For example, this seems to be happening to speech-language pathology for very young children. The cost will be high; these children will begin school at a tremendous disadvantage and are bound to need significant, and expensive, remedial special education. Is there an unspoken assumption that other agencies will pick up the slack? Who is identifying the gaps that will inevitably appear in the spectrum of services available in particular communities? In many cases, no one. Who can move to fill those gaps? Again, existing agencies tend to be stretched to their limits, and who has the overarching mandate to plug service gaps?

"Unplanned cutbacks show the problem of fragmentation at its worst. But our hearings also showed how these problems can be avoided—of how, even in times of fiscal restraint, services can be provided in an integrated and

coordinated way. Service coordination and integration is the second critical theme we want to emphasize in our report.

"We recognize the many barriers to such local integration of services. We know there are communities where such efforts have never been attempted because of lack of leadership or commitment or where efforts foundered in the face of interagency 'turf wars' and bureaucratic inertia. But the fact that barriers to effective planning and service delivery exist does not make the challenge of developing integrated services any less pressing. Nor do we see these institutional barriers as insurmountable.

"Barriers that can be changed, must be. We heard many examples of groups and programs working together in well coordinated and planned ways and of programs and communities that were working towards a more integrated model of service delivery. We applaud these local initiatives. We want to recommend a series of directions that provincial policy could take that would help to facilitate local coordination and integration of services.

"4. Clear mechanisms for coordination and collaboration between relevant local agencies must be a prerequisite for any program to be funded by the province.

"5. There must be special incentive funding for innovative pilot projects on local collaboration and integration.

"Again, we were pleased that the Ministry of Community and Social Services appears to be prioritizing integration and coordination of services in the policy framework it is developing. However, many of our witnesses expressed concern that deliberations on these issues had been going on for so long. For example, the 1990 report of the provincial-municipal social services review addressed many of these questions of coordination and responsibility. We urge the minister to make an immediate announcement accepting our two recommendations above and indicating how they will be reflected in funding mechanisms and priorities.

"We are concerned that the presentation from the Ministry of Community and Social Services did not address the problem we highlighted earlier of unplanned program cuts and their local impact. And, perhaps even more fundamentally, while we recognize that MCSS is aware of the need for interministerial coordination, it does not have the mandate to require collaboration with the other relevant ministries. Only the government has the power to bring all the relevant ministries to the table and tell them to get on with the task of coordinating their services for children. We would hope to see a clear direction from the Premier that this interministerial coordination is a top priority. We recommend that:

"6. Ministries involved in providing, funding or mandating services for children and youth should urgently explore means of collaboration and coordination between ministries. The goal must be to both reduce needless duplication and administrative complexity and to ensure that the full array of services is equitably accessible to children and their families who need them.

"Local Initiatives

"We have recommended that policy and funding facilitate local integration of service delivery. But we agree with Yours, Mine and Ours that provincial bodies, and indeed legislative committees, cannot be prescriptive on how this local integration should take place. Local providers and community members are best placed to decide on the particular configuration of service provision that meets their needs.

"We agree with witnesses who argued that pilot projects that seek to implement visions of coordinated services and that build on local community strengths should be supported. Our recommendation above for funding pilot projects would greatly facilitate such local initiatives.

"We also heard the various youth groups that appeared before us, supported by the Premier's Council, argue that youth must be involved in policy and program development when it affects them. Other witnesses stressed the importance of community and consumer input to the success of their programs. We recommend that:

"7. Funding for the new directions of preventive and integrated programs that we have been emphasizing should also be contingent on community and consumer input to program planning and operation.

"We note that the Ministry of Community and Social Services is considering requiring that agencies they fund have boards and staff representative of their communities and mechanisms for consumer and parent input.

"Children's Services as an Investment in Our Future

"Witnesses made a strong argument that public spending on children's services is an investment in a productive and prosperous society. And they showed all too graphically that insufficient investment in addressing the conditions that place children at risk has enormous costs in the future. We endorse the argument made by service providers and the Premier's Council that, even in the tightest economic times, children's services should be a top priority for public funding. Fiscal restraint need not be a time for retrenchment; it simply means that limited resources have to be used in the most effective and imaginative way possible.

"The government must recognize that expenditures on children's services are a sound and essential investment in our collective future and must ensure that the needed programs have an adequate and secure financial base. We recommend that:

"8. The province ensure that vital children's services are adequately and stably funded.

"Summary of Recommendations

To summarize, the committee has recommended that:

"1. Programs geared to the prevention of child abuse, neglect and poverty must be a high priority for government funding.

1620

"2. The Ministry of Community and Social Services, in conjunction with other relevant ministries, identify and remove legislative and policy barriers that curtail children's services agencies' ability to provide preventive programs and services where appropriate.

"3. The Ministry of Community and Social Services, in conjunction with other relevant ministries, ensure that the mandates of children's services agencies clearly allow them to provide preventive programs when they and local communities consider it appropriate.

"4. Clear mechanisms for coordination and collaboration between relevant local agencies must be a prerequisite for any program to be funded by the province.

"5. There must be special incentive funding for innovative pilot projects on local collaboration and integration.

"6. Ministries involved in providing, funding or mandating services for children and youth should urgently explore means of collaboration and coordination between ministries. The goal must be to both reduce needless duplication and administrative complexity and to ensure that the full array of services is equitably accessible to children and their families who need them.

"7. Funding for the new directions of preventive and integrated programs that we have been emphasizing should also be contingent on community and consumer input to program planning and operation.

"8. The province ensure that vital children's services are adequately and stably funded.

"Our last recommendation is that:

"9. Under standing order 37(d), the standing committee on social development is calling on the Minister of Community and Social Services to respond to this report in a comprehensive fashion within 120 days."

That is the section on the conclusions and recommendations. I would now like to call on members for comment before I move adoption of the report and begin with the member who brought this before us, Ms O'Neill.

Mrs Yvonne O'Neill (Ottawa-Rideau): I'd like to begin by saying how impressed I have been with the way in which, over such a short period of time, both the children and youth and the people who work with children and youth in this province were able to present this committee and indeed the government with such useful information. They brought their experience and their professional efforts as well as their research to our subject.

Like you, I would like to particularly mention the Yours, Mine and Ours report, because I thought we were very fortunate to have the authors of that report available to present their fresh-off-the-press document to us. Then so much of what we heard in subsequent testimony reinforced that initial presentation and was complementary to that report. We hope this government will take this important document very seriously.

The committee heard, and I among them, over and over again the words "prevention" and "integration." Many of the statistics we heard regarding the number of children considered at risk were much less than comforting. It became clear to us, as we heard the witnesses bringing their professional and experiential knowledge to us, that there are certain economic conditions and social conditions that directly relate to children at risk. Poverty, inadequate housing, a family history of abuse, addiction to both alcohol and drugs within the home and social

isolation are some of those. But that which was most worrisome to some of us on the committee, and indeed me, was the fact that there continues to be growth both in the category of children in care and children needing and seeking services; indeed, thus, children at risk.

There's no question in anyone's mind at the end of these hearings that healthy children and youth are a benefit to all of us and that children and youth must be a priority on the public policy agenda. Our committee heard, and we agree with, the following statements: that integration and coordination must be seriously addressed; that common intake and evaluation procedures must be considered; that parents must be supported in their efforts right across this province; one that we all knew before the hearings but I want to emphasize, that the prenatal period is crucial to both mother and child; and that high-quality child care is a fundamental need for many.

Opportunities must be provided for the young people in decision-making that affects their lives. They brought that to us, we've heard it in other forums, and I want to emphasize that. Youth representation on all public agencies serving this age group would be an important start.

Many successful programs, those who work in them and those who are served by them, made presentations to our committee: Better Beginnings, Better Futures in the cities of Ottawa, Guelph and Kingston; Renfrew County Board of Education and children's aid societies working jointly on child safety and protection; the Brant family resource centre; the Babies Best Start program in Scarborough. This program involves early intervention and parent education to promote optimal development of new and isolated parents and their infants. It's a six-week program delivered in 30 different languages by home visitors, and it's showing already significant reductions in both child abuse and neglect. We also heard of very successful collaborative efforts between hospitals, children's aid societies and other community groups.

Through these exemplary programs individuals gain a sense of self-esteem and develop many practical skills and learn indeed to use the resources in their very own communities. These programs that I've highlighted and others that were mentioned to us are all community-driven and they serve needs that are well known to both those who sponsor and provide the services and to those who receive those services.

The long-term benefits of successful programs like these are that participants are better prepared to do their part to build healthy families and healthy communities, and many of them proved to us that they could do it, even within the limitations of being on social assistance.

The participants acquire practical applications of what they've learned, whether that be new social skills, early recognition of childhood illnesses or preparation of nutritious Canadian meals.

Now to get a little more technical, we heard from many of the presenters that interministerial collaboration is absolutely essential and indeed would be cost-effective. We heard that we must develop an integrated approach to the delivery of specialized services.

Other presenters indicated that alternative dispute mechanisms and access to alternative court measures, such as mediation, are indeed underutilized and should be considered as valuable and effective strategies.

The children's aid societies brought to our attention difficulties within the Child and Family Services Act which indeed need further examination.

I would also like to mention native children, as these children are faced with very distinct barriers, and it's tragic for us to have to recognize that a majority of our first nations children are at risk. The challenges they face are the assimilation policies by both federal and provincial governments right across this country. These children, once in difficulty, are forced to deal with a legal system which does not conform to their traditions or culture.

Children and youth must be a priority on the public policy agenda, and this prioritization must be reinforced by funding commitments to prevention strategies, incentive funding for projects that are based on local collaboration and integration based on interagency service responsibility agreements.

I believe this has been a very valuable set of hearings and I do hope this government and successive governments will use our report as a fundamental resource in all future policymaking in many ministries: Health, Community and Social Services, Education and Training, Culture, Housing and Transportation, to highlight the key players.

1630

Children at risk are a valuable, indeed precious resource in jeopardy. Together we must work to bring every child in this province to his or her fullest potential. The social, physical, mental, emotional and intellectual health of our young people just can't be taken for granted. It's our collective responsibility.

Mr Cameron Jackson (Burlington South): Very much has been said up to this point, through the Chair and through Ms O'Neill, with respect to concerns that have been raised during the process of these hearings. I think they've been extremely helpful by their focused nature, the uniqueness of some of the respondents. In my nine and a half years at Queen's Park, almost exclusively in social policy, there were some very significant presentations that I thought brought some interesting new information before our legislative committee, and to that we can express our appreciation and the pages of the report can express that as eloquently.

There's no question that as we sit in a period of restraint in terms of the ability of any government in this country to deal with a lot of its fiscal challenges—we've been, in this province, operating with an expenditure control plan, with restrictions on the social contract in terms of the ability to expand services on the basis of need—nowhere has that been more critically underscored that complications arise in a society when those kinds of decisions hamstring vital social services.

I think what the report has to underscore, first of all, is a flexibility model which allows any government the authority in which to respond in a positive way, in a

proactive way and, as the report underscores at length, with a prevention focus as well to ensure that children at risk are less at risk in this jurisdiction.

Since the committee began, we have seen some national and international statistics emerge that were just announced, one just in the last 48 hours, which showed that the level of poverty affecting children in this country is far too great and far too high when we're compared with other industrialized nations around the world, and yet we have some of the highest social assistance rates in all of North America. So when one considers that in the midst of so much wealth we're sitting with these kinds of circumstances, clearly the role of government to date has not served the children of this province as well as they could be served.

The report contains some substantive recommendations, but the one that deals with flexibility models is extremely important, because I think the rigidity occurs at all levels. It occurs with families, it occurs with agencies, it occurs with ministries within governments and it occurs between levels of government.

The second area that this report speaks to, which I'm very pleased to see, is the disentanglement model. Quite frankly, the public is fed up with basically public turf wars or turf wars that occur openly at meetings between various agencies. The Chair has alluded to the issue of speech-language pathology, which is an area that I raised and is of great concern to my community, where those services are being buffeted around by virtue of three different ministries, some wishing to lay claim to it as long as the other ministry will pay for it and so on and so on. The bottom line is that behind these controversies lie children in need, and the list of those children and their needs is growing in this province.

I don't think it serves much, at this point, to reiterate a lot of the problem areas, but I am pleased that we have devoted a certain amount of time to native children, because the levels of solvent abuse and other forms of abuse among native children some are referring to as epidemic proportions. But we know, throughout North America, that in the jurisdiction of Ontario we have the highest suicide rates and other statistics which are now starting to come forward.

In giving that compelling evidence, it's clear that we really must respond to some of their cultural concerns. The fact that we are teaching third-language instruction in many of our schools when some native languages are at risk of disappearing off the face of the earth, it strikes me that we've got our priorities somewhat skewed and that these children have a right to have their language and their culture preserved if that's in fact the process by which true healing occurs within their community. That requires a commitment of dollars; there's no question about that.

But I pose the question that perhaps teaching a third language in our public schools might be an appropriate tradeoff so that an Ojibway child can receive proper healing in northern Ontario, in those communities, through agencies which are culturally sensitive and where there are language linkages and so on and so forth. There's compelling evidence that we have a large cohort

of children who are more than just at risk. As I say, their suicide rates are incredible, to say the least.

I wish to say that this is yet one other excellent report. I think all three political parties can be extremely proud of being the government and producing excellent reports. I think all three political parties have governed and produced excellent guidelines and objectives for reform. But clearly, as I go back to my original point, in these tough economic times the process of setting priorities is a process whereby our children have got to be protected as our first priority, and our second most important priority is the elderly, because they are the two most vulnerable in our society.

But children especially, as was cogently presented before this committee, really do not have any laws to protect them. They are, in legal terms, treated like chattel. That's "chattel" I said, which is a legal expression that they are deemed to be the property and responsibility of some person who is deemed to be an adult in our society. That makes them incredibly at risk, just in and of itself. I'm pleased again that the report had the courage to deal in part with part of that question.

So to all those who've presented to this point, I join my colleagues in thanking them for the presentation. I can only indicate that, without getting into partisan terms, I think my party has made some efforts at speaking to where we would try and find some additional moneys. But that's not what this report is about. I simply want to indicate that if all three of our political parties begin talking and dedicating revenue towards children at risk, we will be able to find the solutions that we so desperately need to ensure that all our children have equal access to the best life chances that our society has to offer them.

On that note, I want to again express my pleasure that this will be a unanimous report and that there should be, I would hope and trust, no need for any minority reports on such an important and sensitive issue as the future of the children of this province.

Mr Randy R. Hope (Chatham-Kent): I think one of the important steps Mr Jackson has just indicated is that it is a report that's being put forward by all three political parties which are represented on this committee. On that note, I must say to Ms O'Neill, Mr Jackson, Ms Cunningham, and my own colleagues on this side, Mr Martin, Ms Carter and, I know, Mr Owens, who participated, and Mr White, it was a snapshot opportunity, because it was in only 12 hours that we were able to do this. It is only a snapshot approach to it.

I thank all members of the committee for the view with which we were trying to approach this, to deal with a consensus, a realistic approach, something that could be achieved for the betterment of our children and our community. In those remarks, I know, as also indicated by Ms O'Neill, the Premier's Council report Yours, Mine and Ours was a model of a professional—and when I say "professional," I use "professional" on all levels, from business to labour to consumers—approach that was brought forward, because what it did was tell us how important our children really are.

We had our business community tell us how important they are; we had our professionals tell us how important they are; we had parents tell us how important children are, and how important it is for us as a community to come to grips with different agencies, and perform a function of working together. We never thought we would ever have to do this in good economic times, that we could be on our own and be a separate identity, but under the circumstances that were indicated, under constraints, we have to work closer together. Being leaner doesn't necessarily have to mean being meaner. We can be leaner. We can be leaner through the administration; we can be leaner in the way we do our job; we can be leaner in accessing services for the parents who are looking for the service, because it is such a large service network out there.

I know I will have my opportunity in much deeper detail to respond to this report, because we'll have the 120 days to try to write answers to all this. But I think just knowing the report and its intent, through the conversations that have taken place, there has been strong sincerity of trying to resolve our problems in our communities as leaders at the provincial level. It's now going to take, I firmly believe, even though the report is a very positive report, leadership from our communities, leadership from everybody, every walk of life that is possible in our communities to make this report become a reality. I believe the turf wars that we heard and know about have to stop, and we have to look towards a more positive way of resolving and making sure that the service and the prevention issues are brought forward in our community.

I'm not going to go on at length, but I thank all those who participated in this process, who came before this committee from areas around, because whatever might be good for the Kent county jurisdiction may not necessarily be good for the Ottawa jurisdiction in its resolution to children's services. That's why I believe with the generic senses of direction of which we have to go as a provincial body and as provincial leaders and as a ministry, community leadership will have to set their goals and objectives around the same framework. That may vary differently from community to community.

I would just like to thank again all those who participated in coming across this province to present themselves to this committee. I do thank my colleagues of all representative parties who were here and to you, Mr Chair. Also, I must indicate to the people we sometimes forget, the legislative research and others who have taken the time to help us write this report and to our clerk who has made sure that the appropriate people were here on time and in place, I'd just like to say thank you and I look forward to responding to this report in great detail.

I also look forward to seeing the new challenges, the new, innovative ways that communities will set up to make children our priority of our future and hopefully to come back within a year or more from now in praise of those glorious changes we as a committee have put forward, making sure reality was a part of our future.

The Chair: I'm sure I speak for the committee when I wish you well as you respond over the next while.

To committee members, I regret that as always with the section 125 hearings, we're under a time constraint. I'm going to recognize Mr Martin, who will have a few minutes to make comments, but I'm afraid then I'm going to have to move the motion, as our 12 hours, not unlike Cinderella, are quickly finishing.

Mr Tony Martin (Sault Ste Marie): I just wanted to put a couple of comments on the record, having sat in on this very valuable undertaking and heard some really interesting things presented and certainly some challenging stories told, to say first of all that I appreciate and understand the excitement that some of the folks who came in front of us had around some of the opportunities they've had through some very richly funded programs that they were able to model, pilot, in their communities and certainly they have produced some exciting results in some instances.

But I think it would be remiss of us if we didn't give some credit to the many, many folks out there today who are working in communities with the resources that are presently available and with resources of their own making and their own ingenuity to try to help children and communities grapple with some of the challenges that face children at risk, to encourage them to keep on and to let them know that we understand that resources are often not there to have them go the extra distance or give them the extra help they need to deliver in the way they would like.

However, I'd also say to them that certainly I understand here that taking care of children at risk is not something they can do on their own. They need the help of the whole community around it. As has been said in some native circles, it takes the whole community to raise a child. I think that needs to be said over and over again.

The ministry has since sometime in 1992 set out on a process of pulling together a policy framework or putting in place a policy framework around the delivery of services under family and child services. I know in my own community they have been pulling people together for the last 18 months to talk about how we might better coordinate and bring cooperation to this question. It's not always that easy a task; however, they are committed to it and keep working at it.

Many of the people who came to that table, who have spoken to me, tell me there is enough money in the system as it now exists. It's just that enough of that money is not being spent in the trenches delivering service directly to the children and to the families that need it. It's being spent in other ways, sometimes propping up administrative systems that are often too many in communities. I think we need to be focused on that.

I think if we're going to change the way we deliver services, we have to be hopeful and encouraging of people to be open to change, particularly those who have over the last few years become entrenched in bureaucracies that after a while tend to sometimes feel like they're simply there to foster themselves. So all of us I

think have to be committed to that exercise, because if we're not, we won't get to the bottom of this and change will not happen.

I just wanted to put those few comments on the record, my own personal commitment to being available to be helpful, and I know that our government and all here who have spoken certainly have said the same kind of thing. So I'm hopeful. I think it can be done. I think the resources are there. It's just a matter of how we deliver them.

The Chair: Thank you very much. Could I then put two questions to the committee, following which I'd just like to offer a few thank yous of my own. The two questions are critical. The first one is:

Does the committee agree to adopt the report on Children At Risk as presented? Shall I present the committee's report simultaneously in English and French and move the adoption of its recommendations? All in favour? Agreed.

Secondly, does the committee wish to request that the government table a comprehensive response within 120 days of tabling of the report, pursuant to standing order 37(d)? Agreed.

Just briefly, a number of you have said this, but I would like, as the Chair, to thank the witnesses who came before us. Again, there's a record in terms of the 12 hours of hearings. A number of members have mentioned that 12 hours is a very short period of time, but I think the substance that we received from the witnesses, the Premier's Councils, the youth groups, all of the others, the hospitals, children's aid, children's mental health, those working with young offenders, there's a public record there that I hope those watching or who later read our report will dip into, because I think there's a lot of extremely good observation and material and thoughts there. So on your behalf, a very strong thank you to all the witnesses.

Again, I want to echo Mr Hope in particular to thank both Bob Gardner and Joanne Boucher for the tremendous work they have done in both summarizing the vast amount of material that we heard or was presented to us and then working with us on the report. We thank you both for all of your work. It was much appreciated.

As always, thanks to the clerk, Doug Arnott, for ensuring that somehow we got through all of the hearings and ended up with our report.

I would like to especially thank all of the committee members who've participated. Committee hearings on issues such as this are difficult and I think it was very important that with this one we really did succeed in working together, coming forward with the unanimous report. With that, thank you all.

The standing committee on social development stands adjourned until the call of the Chair.

The committee adjourned at 1651.

CONTENTS

Tuesday 21 June 1994

Draft report: Children at risk S-1597

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

***Chair / Président:** Beer, Charles (York-Mackenzie L)

Vice-Chair / Vice-Président: Eddy, Ron (Brant-Haldimand L)

***Carter, Jenny** (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

***Hope, Randy R.** (Chatham-Kent ND)

***Martin, Tony** (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

O'Connor, Larry (Durham-York ND)

***O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

***Rizzo, Tony** (Oakwood ND)

***Wilson, Jim** (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Bisson, Gilles (Cochrane South/-Sud ND) for Mr Owens

White, Drummond (Durham Centre ND) for Mr O'Connor

Also taking part / Autres participants et participantes:

Jackson, Cameron (Burlington South/-Sud PC)

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Gardner, Dr Bob, assistant director, Legislative Research Service



S-58

S-58

ISSN 1180-3274

**Legislative Assembly
of Ontario**

Third Session, 35th Parliament

**Assemblée législative
de l'Ontario**

Troisième session, 35^e législature

**Official Report
of Debates
(Hansard)**

Monday 15 August 1994

**Journal
des débats
(Hansard)**

Lundi 15 août 1994

**Standing committee on
social development**

**Comité permanent des
affaires sociales**

Long-Term Care Act, 1994

**Loi de 1994 sur les soins de
longue durée**



Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944 – 1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Monday 15 August 1994

Lundi 15 août 1994

The committee met at 1005 in room 151.

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. We are beginning today our hearings on Bill 173, An Act respecting Long-Term Care.

We have the Minister of Health with us this morning, but before I turn to her we have just a couple of orders of business. Mr Wessenger, I wonder if you'd be good enough to start us off.

Mr Paul Wessenger (Simcoe Centre): Yes, Mr Chair. I'd like to move that the report of the subcommittee held on Monday, July 11, 1994, be approved.

The Chair: All right. Members have received that report, which basically sets out the schedule of the hearings. All those in favour of the subcommittee report? Opposed? Carried. Thank you very much.

There will be a brief meeting of the subcommittee at the conclusion of our hearings this morning, just on a couple of matters affecting the rest of the schedule.

MINISTRY OF HEALTH

The Chair: With that then, as I noted, the Minister of Health is with us. Minister, welcome to the committee, and I'll turn the proceedings over to you at this time.

Hon Ruth Grier (Minister of Health): Thank you very much, Mr Chair. I'm delighted to be here and to say to all of the committee members I hope they had a restful and tranquil summer so far and are here in a benign and generous mood to deal with what's going to be, I think, a very interesting set of hearings and certainly some very important legislation.

The Chair: I should say the committee is always generous, not necessarily benign.

Hon Mrs Grier: I think that this is going to be exciting new legislation that will deal, of course, with long-term care and support services in the community.

As it was pointed out during the second reading debates on this bill, other Ontario governments have been discussing for many years how to organize and deliver better long-term care services.

This government has acted. We carried out the most extensive consultation ever, in which 70,000 people across Ontario were asked what they wanted and what they needed in facility care and in community-based services.

We listened to what we heard and we passed, with the help of this committee, Bill 101, which made major changes in the long-term facility sector. That bill provided a uniform funding arrangement for nursing homes and homes for the aged. It also put in place a fair and consistent resident fee policy, thus ending what had been long-standing inequities throughout the system.

Bill 101 also made it possible to establish a province-wide placement coordination service system to ensure easier and more equitable access to facility care.

Now, in Bill 173, we have introduced long-awaited legislation supporting community services. Committee members will recall that Bill 173 received the support of all parties in the House during second reading, and the vote was unanimous.

Mr Cameron Jackson (Burlington South): On a point of order, Mr Chair: It would be fair for the minister to stylize all three parties, but it was not unanimous. I was clearly on record as voting against the bill. I spoke for a good half-hour in the House about the reasons why I couldn't support it. It's fair to say that there was a majority of Tories and almost all the Liberals supporting the bill, but I clearly did not support that legislation.

Hon Mrs Grier: Mr Chairman, I do apologize. I did not mean to spark a partisan note at this point, and certainly my understanding had been that there had not been a recorded vote and that it therefore passed without dissent. I do not, as I say, wish to make an issue of that and perhaps I can really withdraw that comment.

Mr Jackson: It was my understanding that the minister had heard the debate and would have been familiar with my comments.

The Chair: I think your comments are noted and the minister has changed her comments and will continue.

Hon Mrs Grier: Consumers and their families, service providers, the volunteer sector and people who work in long-term care have been telling us for some time that changes are needed.

What they've said is needed are a number of things: simplified and better coordinated access; increased care and service in the community rather than in institutions; greater flexibility in responding to individual needs; a consumer-focused system that puts customer service first; consistent rules and accountability; and, finally, local planning, governance and management of services.

In Bill 173 we have responded to these needs and built the legislation on the strengths of our current long-term care services. This bill creates a foundation for a more effective community-based, consumer-focused system.

Bill 173 will enable us to achieve one-stop access. That means that communities will be able to develop local multiservice agencies that will offer one-stop access to long-term care and support services. These multiservice agencies will give consumers an easily recognized local point of access to the information and services they need to meet their independent living and health care needs. MSAs, as they've been called, will be governed locally by volunteer boards that reflect the diversity of their communities.

The second thing Bill 173 does is provide improved community services. The bill creates the foundation we need to improve the community-based service network. Such a system will provide more care and support and higher levels of service to people in their own homes and in their own communities. To ensure greater equity of service across the province, the act requires that every MSA offer a specific range of services.

The third aspect is a consumer-focused system. Our objective is to have a system that puts the consumer first and focuses on customer service, and the way to ensure that services reflect what consumers want and need is to give them, the consumers, opportunities to participate in decisions about their own care and the planning and management of services.

To this end, the bill includes provisions that will ensure that consumers consent to services, participate in their own plan of service and have access to their service plan and their personal records and that consumers will participate on the boards of MSAs and through DHCs are involved in the planning process.

The fourth principle is consistent accountability. To improve accountability, Bill 173 introduces a consistent set of rules and expectations that correspond with the functions and roles of service providers under the act. This builds upon the best practices currently in place in existing programs and on the sound experience from the decentralized community-based service systems of the Ministry of Community and Social Services.

Finally, local, volunteer and community-controlled planning is the fifth goal. We want to ensure that that is the kind of involvement and planning that leads to the development of the new system and manages it in the future.

In recent years DHCs have been asked to assume more responsibility for planning and for advising the minister on a broader range of health issues. DHCs, of course, are composed of volunteers and represent the districts in which they plan. In the fall of 1992, district health councils were also asked to lead the planning of long-term care services.

This means that DHCs can design the system that fits their community. There is no cookie-cutter at Queen's Park cutting out plans for long-term care. Each community will develop long-term care programs that suit its particular needs.

DHCs need legislative support for this expanded role, and the bill includes an amendment to the Ministry of Health Act which strengthens and clarifies the district health council's mandate to achieve strong, community-

directed local planning. This amendment creates specific authority for the minister to establish district health councils. Members may be surprised to find that that authority does not exist in legislation despite the fact that the Ottawa district health council, I think, celebrated its 20th or 25th year of operation just last year.

The amendment specifies the functions of a district health council. It provides a means for ensuring that the membership of a district health council and its committees reflects the diversity of the community served and includes both health and social service perspectives in relation to long-term care and support services.

Finally, the amendments provide a mechanism, through regulations, for ensuring that service providers submit plans and other information to the minister and the local district health council and that the public has access to those plans when they are submitted.

Ontario has a long and proud tradition of volunteer involvement in its health and social services. People in their communities recognize the need to come together to help others. Community agencies developed with volunteers playing a large part in their growth and in the provision of services. So, over the years, specialized volunteer agencies sprang up to fill specific needs as our society grew and became ever more complex.

The result has been a patchwork of services. In many areas there are gaps in the system, and in some cases services overlap. The obvious solution is to bring these services together in a logical and coherent system and that's what we're doing with Bill 173, in providing a framework for community-based, multiservice agencies.

Of course, this melding of services into an effective system cannot take place overnight. Each community will have to handle it differently to reflect its own specific needs, history and experience.

That's why Bill 173 provides a good deal of flexibility in moving towards multiservice agencies. It recognizes the differences in time, resources and abilities needed to accomplish this goal. It provides flexibility for communities, the government and the people who work in these agencies to adjust to the changes. It offers volunteers and workers time and space to make the necessary changes to a new and better way of serving those in the community who need long-term care services.

The values and traditions caring volunteers have demonstrated for many years in this province are at the heart of our changes to long-term care. Together we are building on the strengths and expertise of those traditions.

We believe that the provisions in Bill 173 will go a long way to expand and improve Ontario's long-term care system. But it's important to remember that this is part of extensive progress towards changes in long-term care. We've already accomplished a great deal through the passage of Bill 101 and improvements in existing programs.

We currently spend \$2.1 billion on long-term care every year and we will increase that by about \$200 million by April of 1997.

In community-based care the growth has been dramatic. We were spending \$550 million on community

long-term care services in 1990-91. Currently we are spending over \$880 million and by 1996-97 we plan to spend over \$1 billion in this sector.

Let me briefly outline in addition some of the changes and expansions that have already taken place in our long-term care system.

We are building links between hospitals and community-based services through 20 new quick response teams. We have invested \$5.4 million in this program. It's a program that is directed at people who come to hospital emergency departments but who don't require hospitalization. Quick response teams refer such people to the appropriate community-based services, thereby reducing unnecessary hospital admissions. Quick response is a good example of partnership between communities and hospitals and the teams will be operating in 70 hospitals across the province this year.

We are providing \$4.4 million to fund a pilot project that will help people with disabilities hire and train their own attendant workers. This will support independent living for between 80 and 100 people with disabilities and enable them to exercise much more control over their lives. Right now attendant services are supplied by agencies, sometimes without much consumer control.

The integrated homemaker program is one of the key elements in helping older people remain in their own homes. This program is now available right across Ontario. This year we've established 18 new sites to provide integrated homemaker programs, thanks to \$133 million in annual funding from my ministry, plus another \$6 million over two years for training and recruiting workers for that program.

1020

While these changes help to improve community-based services, long-term institutional care has not been neglected. For example, we've already achieved one-stop access for those needing care in a nursing home or home for the aged through our placement coordination services. As of July 1, 1994, this service is now available all across Ontario. Placement coordination will become an important part of multiservice agencies when these begin operating across the province.

As for long-term care facilities themselves, we are investing this year more than \$65 million to expand and upgrade 13 homes for the aged, such as Cummer Lodge here in Metro and the Fairview Mennonite Home in Cambridge.

Development of multiservice agencies is well under way in many communities under the leadership of the district health councils. Already I've received from the Metropolitan Toronto District Health Council its plan for how MSAs should be configured to meet the diverse needs of Metropolitan Toronto. I look forward to receiving plans from other district health councils later this year.

In addition, many communities are seeking district health council support to allow them to put multiservice agencies in place as soon as possible. I support this idea of early leaders where communities are ready and where district health councils believe that the early leader that's

proposed is in conformity with the plans that are emerging through the district health council.

It was recently pointed out to me that acute care is often about procedures but long-term care is about relationships. I'm very proud of Bill 173 and the relationships it is building on, as well as the new relationships that will develop to provide the best care for our communities.

Thank you again, members of the committee and Mr Chair, for the opportunity to appear before you. I trust that the schedule of hearings you're about to embark upon is very productive. There is enormous interest in these reforms across the province, and I know that you will not lack people who wish to come forward and make comments to you. I certainly will look with interest at your comments as a result of that.

I know that you're going to have a technical briefing when I've finished. I just wanted to indicate that with you and following the committee hearings will be Gail Czukar, who is the legal counsel for the Ministry of Health; Geoffrey Quirt, who I think has appeared before this committee, as has Gail, on many occasions, acting executive director of the long-term care division; and Joanne Gottheil, legislative counsel who drafted Bill 173.

The Chair: Thank you very much, Minister. As you have noted, the next part is the technical briefing by ministry staff. The minister is able to be with us until 11 o'clock, roughly, so that if there are questions as we go along with the technical briefing, I would certainly welcome those as we go along. But I just note for members that the minister will have to go at 11, so if there are some specific questions that members would like to put to her, you could keep that in mind. The clock there I think is about correct, so we have about 35 minutes.

I then call on the ministry staff, if they would be good enough to come forward. While you are known, I think, to most of us around the committee, given that we are also in living colour, perhaps you would be good enough to identify yourselves for everyone else who is watching.

Mr Geoff Quirt: Thank you, Mr Beer. I'm Geoff Quirt and I'm the acting executive director of the long-term care division. With me is Gail Czukar, who is counsel for the Ministry of Health on the long-term care bill.

The minister has spoke to you about how proud she is of our new bill. We share that feeling. She has also talked to you about the objectives of the bill, what we hope to accomplish with it. What I'd like to do in my brief remarks is to follow up on the minister's reference to those objectives and provide you with some concrete examples of what will be different and improved for consumers and volunteers in the long-term care system as a result of this bill passing.

I recognize the time constraints and I want to leave time for the minister to respond to some of your questions prior to her departure at 11.

The minister talked about one-stop access and the provision for the first time of one place, one contact number where consumers can gain access to the full

range of long-term care services in Ontario. This, we think, is perhaps the most important objective that we'll achieve through the passage of this legislation.

Let me give you some examples of how things will be different for consumers as a result of the passage of this bill and the achievement of one-stop access to long-term care services.

As you know, in Ontario currently an elderly person and their family may receive services from three or four or sometimes five community service agencies, each doing an important job in meeting a very important need of that consumer and family. Our system's structure, however, makes it very difficult for those organizations to cooperate and deliver services in a coordinated manner. In Ontario we've had a system to date that gives the responsibility for deciding how much service some person is eligible for to one group of agencies and the responsibility for actually delivering that service to another group.

For example, if someone needs homemaking or nursing services, 38 home care programs across Ontario decide how much someone's eligible for, but when it comes to actually delivering that service, delivering the nursing service or the homemaking service, they could call upon a range of other agencies, the VON and the Red Cross and other agencies, for example, to actually deliver that service. In addition, there are over 1,000 community service agencies that deliver support services like Meals on Wheels and transportation.

In a nutshell, those efforts to coordinate services will be greatly improved through the integration of those two functions. In other words, the multiservice agency brings together the responsibility for deciding who's eligible for how much under what circumstances with the responsibility for actually delivering those services. So those decisions are made under one roof in one organization.

What does that mean for the consumer? Rather than having a home care employee visit and do an assessment and then have the VON nurse come and visit and do a similar assessment and having a representative from the Red Cross come and ask similar questions, it means that one agency, or one group of people, can take collective responsibility for saying, "Yes, Mrs Smith, you need nursing services, and we think a homemaker would be helpful to you as well, and a meal program. I've got responsibility to say I'll be back tomorrow to help you change your dressing and my colleague in the next office will come to help you with your homemaking needs and I'm sure that one of our volunteer coordinators will ensure a meal comes tomorrow as well." So we bring that responsibility together to let thousands of workers in the long-term care system, who are doing an excellent job now, do even a better and more coordinated job for people in the future through one-stop access.

The minister spoke about an improved community-based service system and talked about how services would be better for clients and consumers. Let me give you some concrete examples of how that will change.

In Ontario we've relied on eligibility criteria that are consistent and service limits that are consistent across the province. In other words, we've said that, as a provincial

rule, homemaking can be limited only to 60 hours for people, regardless of their individual circumstances. Because we've had so many organizations and agencies relating to us, each has had its own set of eligibility criteria and its own rules about how much service can be delivered. By bringing the responsibility for service delivery together in multiservice agencies, it lets us be much more responsive to the actual service needs of consumers. Let me give you a couple of examples of how we'll be doing that.

One important example is to ensure that key services, mandatory services, will be available in each community, and the bill requires that multiservice agencies deliver a full range of long-term care services. So it won't matter any longer whether you happen to live in north Frontenac or in downtown Toronto. The law will require that the multiservice agency in your area will have a range of appropriate services to meet your needs.

How did we pick those services? We listened to 70,000 consumers and hundreds of service provider organizations who suggested to us what the most important services should be to meet the long-term care needs of the majority of our clients. So that's the first consumer-oriented service improvement the bill makes possible.

1030

Secondly, the bill allows for a great deal more flexibility in how services can be delivered to consumers. Let me explain a couple of ways in which multiservice agencies can be more flexible than our current system is now.

I mentioned earlier that our home care program is limited by provincial policy to providing a maximum level of service across the board to individuals. This doesn't allow our workers on the front line to differentiate between the needs of individual clients and families to the extent that they should.

As a result of providing an improved range of eligibility for services the MSA delivers, our front-line workers are going to be able to decide that in this particular case, with this client or this family, a much higher level of support is important and necessary to keep someone from having to, for example, have their long-term care needs met in a facility.

It allows us to service-target; it allows us to say, in a fair way across the province, that in these sets of circumstances someone is eligible for a great deal more in-home support than they would have got under the previous system. Because all the players are involved in the delivery of that service plan, we avoid the problem that one agency considers the case a priority while the other agency doesn't. It allows us to have the decision-makers about what range of programs and services collaborate under the same accountability system to decide what's fair for a particular client and consumer.

What would be different for volunteers as a result of improvements in the community-based service system? This is a very important topic, and I'm sure the presenters will talk at length about the importance of volunteers in their long-term care system. I don't think anywhere in Canada you would find a more cost-effective range of

programs than the home support programs currently at work in Ontario, where provincial funding really goes to coordinate volunteer effort, the thousands of volunteers who make a great deal of impact on the ability of consumers, elderly people and people with disabilities, to stay at home and live independently.

What will be different as a result of our service improvements for volunteers? One thing we want to be sure to do is that each multiservice agency is equipped to do even a better job than the current system does in recruiting, attracting volunteers and training them so that they feel comfortable discharging the responsibilities they have, supporting the volunteers not only by reimbursing their expenses but through training activities and so on, and recognizing the volunteers for the tremendous effort they provide and the tremendous impact they have on our service system.

Contrary to the opinions of some, we see multiservice agencies as the vehicle through which to equip communities to attract even more volunteers in the long-term care system, train them better and, secondly, to allow them to become more flexible players in the long-term care system.

If you and I were to volunteer now in many communities, if we volunteered for one agency, we'd be volunteering to drive our car around and deliver meals. If we decided to volunteer for another agency, we may be called upon to make a visit to an elderly person who's shut in, who doesn't have much contact, and to just go and make sure he or she's all right and chat and provide a friendly visit.

If we thought it would be reasonable to not only deliver some meals but perhaps drive somebody to the hospital while we're out on our route, we'd have to get in touch with a third agency sometimes and say, "Look, I'd like to volunteer for your transportation service." Volunteers would have to relate to three agencies if they were interested in doing that for their neighbours in their community.

With the advent of the multiservice agency, volunteers can become a more effective and more flexible part of a team of workers who meet in a more flexible way the long-term care needs of consumers.

We feel that the community-based service system will be improved not only from the point of view of consumers, who will have a more flexible service response at their disposal, but also from the point of view of volunteers, who will become fuller players, a more flexible, important resource in the community-based service system.

The minister talked as well about—

Mrs Barbara Sullivan (Halton Centre): On a point of order, Mr Chairman: We had thought that the minister would likely be here for the entire morning session. Since we have a fairly general overview of the philosophical intent of the bill from the ministry officials now, I wonder if we could proceed, and interrupt the ministry officials at this time, to address questions and comments to the minister particularly and then continue with the technical briefing after the minister's departure.

The Chair: If that is agreeable to the committee. I know the minister does have to go at 11. That would leave us some 25 minutes if there are questions, and then we could go back and continue with the technical briefing. Is that okay?

I have then Ms Sullivan, Mr Jackson, Mr Malkowski, who have indicated a desire to ask questions or speak, so perhaps we'll do that, and Ms O'Neill, if there's time, and I'll try to include others as we go along. We'll begin with Ms Sullivan and come back later.

Mrs Sullivan: Thank you, Mr Chairman. There are a number of issues that I want to place to the minister and ask for her comments on with respect to this particular bill on long-term care reform in general.

The first, of course, is with respect to the dollars which are constantly quoted as being the government's commitment to long-term care reform over a multi-year period. The \$647.6 million is frequently quoted. We have asked on numerous occasions for an enumeration of how that money is being spent, what is projected, where it's being spent. We certainly know that there has been inaccurate forecasting in some of the funds that are included in that package of \$647 million. The most obvious is the \$150 million which was expected to be raised in facility fees from residents of long-term care facilities. That clearly did not come through. That's very obvious from the ministry's estimates.

One of the things that is of deep concern to us and to many people who are very involved in long-term care reform is the accuracy of the data and the financial projections on which this reform is based. That is key and important for a number of reasons, not the least of which is that we hear promise after promise of a better future ahead in long-term care reform. Frankly, we believe that people should have their feet on the ground rather than their heads in the air about what actually will happen, what will be promised and in fact what it is possible to deliver.

We know there has been no feasibility study of the costing of any MSA in any region. We would like to see more of a pragmatic approach to the design, including the financial design, of a multiservice agency in each community or in a number of communities. That hasn't been done. We'd like to know why that hasn't been done.

With respect to the bill itself, once again the director has spoken, as has the minister, at some length on the emphasis of linking together the assessment and delivery functions and indicating that that linking is a necessity to assure appropriate care. We are concerned that the kinds of assessment that are contemplated under this bill don't include the treatment assessments which are so vital for ensuring that people have the appropriate care that they require over the long term. Unless it's the minister's proposal to include medical care as part of the MSA, ie, doctors on staff or something similar, in fact the entire long-term care spectrum and analysis of the patient needs will not be taken into account.

The minister talks about treatment aspects, medical aspects, being procedures, and long-term care being relationships. In our view, that's facile verbiage. Long-term care is far more than simply social and other kinds

of relationships. It includes very much a part of care delivery. In fact nursing care is a part of long-term care, and we'd like to have the minister's comments with respect to the assessment function and where the treatment aspects are taken into account in that.

The other thing we find hard to understand is why the minister is so committed to the linking of assessment and delivery. It seems to us that that linking isn't necessary if there is an accountability function at the assessment level for follow-up with the person who's involved. We would like to hear the minister's comments with respect to that.

1040

Certainly the minister appears to contemplate that kind of approach in that there is an exemption in this act, for four years after the designation of an MSA, for an assessment plus service delivery from elsewhere in the community. We would like to know how that four years was chosen, why it was selected and whether the minister would consider eliminating the four years so communities can in fact choose what meets their needs.

Neither the minister nor ministry officials have satisfied our concerns with respect to volunteer activity, and I'm fascinated with the scenario that was painted by ministry officials about how volunteers select their philanthropic volunteer activity.

There are two issues here. One is with respect to those agencies which are mission-oriented, and I speak particularly about religious agencies, whose volunteers want to work with a particular and in a particular religious environment; and similarly, those volunteers who work in a cultural environment that is frequently based on ethnicity, but there may be other cultural surrounds to that.

We feel that the volunteer sector in terms of the activity base will be, if not decimated, certainly reduced, and that has been the circumstance in other provinces, notably Quebec, when similar models were put into place.

The issue that has not been addressed, however, is the volunteer activity associated with fund-raising. A significant amount of social agencies that are providing long-term care is supported by fund-raising activity in the community at the volunteer level, a different kind of volunteerism than exists in actual care delivery. We'd like to know, first, what assessment has been made of the funding that comes out of the volunteer fund-raising process, and how the minister suggests that could be replaced.

There are a number of other areas we would like to ask the minister about. I'm not going to take more time now because time is so limited. Some of those include the minister's views with respect to labour rights of those people who are already involved in the volunteer agencies and their transfer to the new MSA, the issues with respect to the appeal process, and the liability issues that are associated with what will become statutory requirements for employees now, rather than volunteers, to deal with issues such as banking and finance.

There are lots of other issues. I'm sorry that the minister can't stay longer, because we would like to hear

direct from the minister's mouth responses to some of these issues.

The Chair: I wonder if in the interests of time it might be worthwhile to move to the Conservatives—

Mr Jackson: And of equity.

The Chair: —and equity, and then, Minister, if that's all right, to Mr Malkowski, and then you could respond, just to make sure we get the questions on the record. In all of those interests, I turn to Mr Jackson.

Mr Jackson: Thank you very much, Mr Chairman. I'd like to welcome the minister for her brief appearance before these important hearings, but I have to focus some of my questions on what the real facts are about the situation affecting long-term care in Ontario today that bring us to this very moment in our hearings.

I certainly have a lot of concerns about the fact that long-term care was started in the late 1980s and then it was sort of put on the back burner and then revived, but I don't think it's useful to get into a long history except for the area—my one question from the past administration has to do with the costing. Ms Sullivan raised that.

It is my understanding from ministry sources that there were feasibility studies done on the costing of the MSAs, that in fact when Ron Van Horne was the first minister for seniors there were four pilots done in Ontario. I briefly had occasion to look at part of a report done in the very late 1980s. One of the communities that caught my attention was in the Cambridge-Paris area of southwestern Ontario. That report exposed hundreds of millions of dollars of necessary seed moneys to pull together this vision of an MSA which both the minister and Mr Quirt stylized in almost romantic terms.

That causes me some concern, because they were the same kind of concerns that were expressed about the financial realities around institutional care amendments and the same kind of romantic notions that were portrayed about life after Bill 101.

I certainly have several unanswered questions I've raised both in the Legislature and in correspondence to the minister and Mr Quirt, but I really do believe this committee deserves the right to have a look at those reports. Albeit they were developed by the previous government, there were pilot moneys, taxpayer dollars, invested in a variety of communities in Ontario to develop one-stop access for seniors' services, and the reports came back with horrendous dollar figures attached to them.

I'd like that information because the minister, by her own admission, has indicated in the House—not today, though—that the whole schedule for the implementation of long-term care reform is badly behind schedule, that in fact the hurdle which has been most difficult is the one that is before us: the MSAs and how they're to be constructed, their implementation.

On the one hand we have the reduction of the institutional beds, the choking of a large number of beds and access to services in the chronic care field, without the resultant—this romantic vision of how our long-term care plan with MSAs will be in place. In fact the minister was very careful, or she ran out of time—but she was unable

to give us specific time frames with respect to the MSAs, only that with these early leaders, she was very encouraged by the report.

I'm sure the minister would be willing to share with this committee an example of this wonderful cooperation and understanding about how an MSA should be constructed, and would share with the committee the Toronto model which is before her, even if that were done in a private briefing to this committee, but I think it should be a public document since public boards and volunteers have constructed it.

Hon Mrs Grier: Mr Chair, it is. I think it was released by the DHC some weeks ago.

Mr Jackson: Perfect. That is a concrete one. What we're also looking at are the other early leaders, where the minister announced in the House that there would be potential pilots in place early. We'd like to know how far that has developed. I suspect Mr Quirt would be able to respond to our questions before noon today on that.

The minister expressed that she felt that within this bill it was again a consumer-focused system she was putting in place, that the decisions by the consumer would be more important and more focused, and her biggest example was the consent to treatment, which I thought was already the law in this province, but that's fine.

I thought the cornerstone of consumer choice was access to service, yet within this legislation part XII again has that terrible, terrible clause in it which I disliked so much in Bill 101, that is, the removal of a benefit from the Health Insurance Act, which gives the state—the minister referred to the financial times we live in, but this power transferred to the state is basically to say, "We're lifting some of the previous protections under the Canada Health Act as it's implemented in Ontario." It's hard for me to really accept that the state, coming before a committee as the minister just did, saying: "Look. Trust me on this. This is going to be a more consumer-driven piece of legislation"—but if you look carefully in the act, we're removing the universally accessible component.

1050

When I listened patiently to Mr Quirt's presentation, he stylized this section of this legislation in, quite frankly, romantic terms: more this, more that. He used the word "more" and never once used the word "less." When you go from a system which is somewhat more universal in application, which is the system you describe, sort of a basic standard, and then suggest to the citizens of this province, especially our senior citizens, "This is a really good thing for you people because now we're going to have the ability to differentiate"—and the examples Mr Quirt used were really positive ones, like, "Boy, we could really move in on a family and say, 'Hey, you need more service,'" but it's fair to say that this bill also says, "You now should get less service." It also, according to this section, goes so far as to say, "You get no service at all."

In my view, that's a fairly serious consequence of this legislation. It is the same consequence, in legal terms, written as legislation, which existed in Bill 101 when we removed chronic care from the schedule of benefits under the Canada Health Act as interpreted in Ontario with our

companion legislation, the Health Insurance Act.

When a person is offered three nursing homes in Ontario and it's completely unacceptable to them either for religious or cultural or for distance reasons, that's it, you're out of luck, no service, or the state says right in the first round, "You can appeal, but you're really just not eligible to be in a home." We're now going to take that new vision of long-term care and we're going to transfer that under the details of how MSAs make substantive decisions about people's lives as it relates to care and support in a home setting. It's consistent, Minister, but it's inconsistent with my conscientious beliefs about how long-term care should be structured in this province.

The concept of "universally accessible" is something which should not be cast adrift, as it is in this legislation, without a fuller and clearer understanding, which brings me to this issue of the 70,000 people who were consulted. It is fair to say that 70,000 people were consulted, give or take a few 10,000. You know how politicians are with numbers: We're all very generous with them.

But I recall the meeting I went to. I was one of those 70,000 who showed up. I just tend to think I was 30 or 40 years early, that's all. But when, asked about the issue of care being not for profit, the question was, "You don't want people to make a profit from long-term care?" everybody said, "No, we don't want that to happen." Therefore that statistic was recorded. But I rose at our public meeting and said: "Just a moment. Do you wish to have a choice? Do you wish to have in place a system like we have today, where profit is governed, rules are governed, but you have access so that you can have certain care at night or on weekends and so on?" Of course the response was completely opposite to the one being taken.

I think we'd best be very careful when we suggest that these 70,000 people in Ontario said, "This bill is a wonderful piece of work," when in fact many of the questions raised at those public hearings do not in any way, shape or form reflect the vision that's set out in legislative terms here.

The Chair: Mr Jackson—

Mr Jackson: I understand, Mr Chairman. Just let me summarize, then. I think we should, during the course of these hearings, get some very clear or straight answers about:

—The funding arrangements.

—We should get some straight and clear answers from staff with respect to the fallout from Bill 101. I'm told that millions of dollars of provincial money that was supposed to be going to home care is being redirected now over to institutional care, because under Bill 101 people's fees went up by some \$160 million and people just can't pay and therefore the province is picking up the slack. I would hope we would get some real numbers on that.

—The issue of the MSAs and their structure.

—The assessment and delivery link components of how that affects the Health Insurance Act.

—The removal of this benefit, which is implicit in this

legislation, and clearly will change access, in my view, for seniors for many, many years to come.

My colleague Mr Wilson and I look forward to the public hearings over the course of the weeks, but we feel there are more unanswered questions than those that are satisfied in the minister's brief but, as I say, somewhat romantic presentation this morning.

The Chair: Mr Malkowski and then, Minister, you can respond.

Mr Gary Malkowski (York East): Thank you, Mr Chair, and thank you, Madam Minister, for a very comprehensive opening. I know my own constituents in East York, with East York Community Care, have been very excited and are very happy to see this legislation coming into being and are looking forward to the improvements in service that are going to take place because of it.

In my own constituency, I have met many constituents who have disabled children. This legislation applies to seniors and disabled people who are adults, but what about the gap in services in terms of people with disabled children, and how can they fit into this type of legislation?

I also want to ask about the role of the district health council. Is there a requirement that there be members of the disabled community represented on the district health council, specifically in terms of the planning stages, making sure that the MSAs are accessible? When I talk about accessibility, I also mean in terms of making sure that the information can get out there, that communication is accessible. I don't see any requirement in terms of the district health councils actually including disabled people in the planning process, and I'd like to know whether there is a requirement that that take place.

My final point would be really more of a suggestion. In terms of seniors, 50% of all seniors have a hearing loss. My suggestion is to make sure that the MSAs are accessible, that information in terms of being able to communicate with this population is provided in an accessible fashion, that there be a guarantee of a specific level of support service. I think we need to have an expansion of that.

Probably the most appropriate place is through the public hearings. We'll be hearing comments from consumers on these issues, I'm sure, but I would like to hear your comments specifically on those three areas.

The Chair: Minister, there are a good number of questions on the plate, if you could try to respond to them. I'm sure staff have also taken note, and some of them we may have to come back to.

Hon Mrs Grier: I certainly will attempt to at least briefly touch on those that have been raised, but let me say that not only the staff but certainly my colleagues have been involved in the preparation of this legislation and the debate about long-term care for the last four years. Both my parliamentary assistants and the parliamentary assistants to other ministers who have been involved in our discussions as a government in what this legislation should contain are very familiar with all of the details, and I know they will be able to respond to

questions and comment as you go through the hearing process.

Let me also say that as I listened to my colleagues in opposition and their concerns, I worried that they were implying that the status quo was somehow acceptable. I say to them that given the changes in demographics, the aging of the population, all of the factors we have heard about in every discussion we've ever had about health care, the fact that we have 1,200 agencies out there providing long-term care, some of them in first-rate fashion but some of them quite isolated from each other, and in anticipation of the bulge in population that will increase the senior population over the next 20 years, it is essential that we finally, after, as Mr Jackson said, more than a decade of discussion, get to the point of not just expanding, improving, but almost creating a long-term care system. We are not beginning that with this legislation. We are putting in place the legislation that facilitates the continuation of the work that has been begun.

1100

Mrs Sullivan asked for details of the funding. I think in our estimates discussion and in the follow-up a lot of that was provided, but let me repeat the figures I mentioned in my comments in a percentage form, because they are dramatic.

Since 1990-91 this government, faced with all of its fiscal constraints, has increased expenditures for home care by 53.5%; has increased expenditures for integrated homemaker programs by 65%; has increased expenditures in funding for home support services by 37.4%; and has increased expenditures in programs providing attendant care by 35.9%. That is the increase in expenditures that has already occurred, and the \$647 million in additional spending that was announced when the program began is largely out there. There is the addition of almost \$200 million that will occur over the next two years on long-term care; I think \$160 million of that on the community support services. Our commitment to not only creating the system but to funding the system is there for everyone to see and for everyone who needs long-term care to benefit from across this province.

When we get into the specifics of what an MSA will cost, I can't at this point produce any specifics around that. I know that some work has been done and I suspect that staff can share that as you get into the hearings.

Mr Jackson mentioned work that was done by one of your colleagues, Mr Van Horne, the minister responsible for seniors' issues. I remind you that that was based on a very different model. That was the previous government's approach, which was to put in place ministry-led service coordination agencies; it was the top-down approach, that was rejected almost universally during the consultations that we began in 1991 and which we have replaced by the growth and evolution of the existing volunteer-led agencies into better-coordinated and integrated, still volunteer-led, agencies. If any costing was done of models based on the top-down service coordination approach, I'm not sure they would be still relevant, and they're not ones I'm familiar with, though I'm certainly prepared to ask if those exist.

The other major change, and Mrs Sullivan referred to it, was the fact that the previous government's approach had been a continuation of the brokerage model. That's the fundamental debate that I think we get into with those who question our approach to long-term care and who suggest that the integration of assessment and provision of services is not required and that all we need is a better coordination of agencies that then continue to contract out and be brokers for the provision of service. We don't believe that is the way upon which we want to build an integrated system for the future.

But acknowledging the difficulties and the concerns people have in the coming together of these agencies in communities was why we moved to a transition period. Mrs Sullivan said, "Why four years?" It was our assessment, from discussions with EHCs around the province and with agencies across the province, of the maximum amount of time that would be required in order for workers, boards, volunteers to come together in a more integrated way. But while we heard from those discussions that people were a little alarmed at the prospect of there one day being 1,200 diverse agencies and the next day 400 or 500 integrated agencies so we acceded to the request or the suggestion that there be a transitional period, certainly it is my sense that well before the end of four years, many of those will come together.

The question around assessment and who does it: the same professionals who do it now. Now assessments are done by hospital discharge planning staff, by home care programs, by placement coordination service programs, by adult day program staff and by community support agencies. The kinds of people who are performing those assessments will continue to perform them, but they will perform them on behalf of the multiservice agency so that, having done the assessment, they can no longer be put in the position of saying: "Well, I've assessed you. You don't fit the needs of my particular agency and the services we provide, but here's a number to call where another assessment can be done by another agency that I think provides the kind of service you need." We will now have one assessment and a direction from that to the kinds of needs that are identified through that assessment.

Mrs Sullivan: I wonder if we could have a further clarification of this assessment role. Clearly, the people who are the new assessors will be employees of a multiservice agency. They will not be hospital discharge planners. In fact, the hospital discharge planners have quite a different role.

When the minister says the same people who will be doing the assessments are those who are doing it now, in fact that's not quite right. I'd like further clarification of what she sees as the role, the qualifications of an assessor who is going to be not from an existing agency but a new employee of a new multiservice agency.

Hon Mrs Grier: The social worker who's now working for a small volunteer agency and doing assessments I hope will be exactly the same social worker who'll be working under the aegis of the multiservice agency and doing the same assessment. The standardization of criteria and the definition of what service is required depending upon what assessment is something

that is being discussed in detail by the ministry and people who've been doing assessments for 20, 30 years.

But I can assure the member that the education qualifications of a social worker working now for the Red Cross are not going to be any different from the education and qualifications of a social worker or a physiotherapist or a nurse working for a multiservice agency.

Mrs Sullivan: But I'm still not getting the picture. If there are treatment requirements, including nursing requirements and so on, surely the minister isn't suggesting that the social worker will make those assessments?

Hon Mrs Grier: No, nor do they now.

Mrs Sullivan: Then how does she see—

Hon Mrs Grier: I use "social worker." I could well have said nurse-practitioner, psychiatrist, whoever was doing it.

Mrs Sullivan: The assessor is the person who comes into contact with the patient.

Hon Mrs Grier: I think we could bog down on this for some period.

The Chair: I think the minister will respond that this may be an issue that we need to continue to explore.

Mrs Sullivan: It's the way people get into the system. It's a very important question. The minister should be quite clear.

Hon Mrs Grier: It is certainly very important and I'm sure it's one that, as you hear from various presenters, will be discussed in more detail. I'd be more than happy to have a specific briefing on that aspect of it as you get into your technical briefings, if that would assist the member in understanding what happens now and how that can be performed in a more coordinated way as a result of the changes we're suggesting.

But I did want to touch on a couple of the other points. One was again from Mrs Sullivan, her sense somehow that volunteers who came from a particular cultural or religious or set of values to their volunteer work would be unable to continue to perform as volunteers with the same values. I guess I don't understand what she's thinking, and that may also come out, but certainly as a volunteer, as I've been for many years in my life, I decide what kind of agency is most compatible with the kinds of objectives and satisfactions I want to achieve as a volunteer, and if that agency doesn't provide me with that sense of satisfaction, there are lots of other roles in which I can fulfil my volunteer responsibilities.

If merely delivering Meals on Wheels becomes not satisfying enough—and having delivered Meals on Wheels, I know how frustrating it is when the person wants you to stay and chat and you really don't have time—you may say, "I'd much rather be a friendly visitor so I can go and spend time with that particular client."

But I bring to that as a volunteer whatever cultural, mission or religious beliefs I hold, and certainly no agency is going to say to you as a volunteer, "You must visit that person and not that person." That is worked out, as it always is, with agencies, and I don't see any of that changing. It's the concept that suddenly by bringing together agencies under one roof everything changes that

I think is unsettling to some people who may feed into that belief or assessment of what's going to happen and that we need to be very clear about.

1110

From my own experience 20 years ago in putting together a multiservice agency to provide health care services, I found that the number of volunteers who came forward to both fund-raise and to volunteer expanded as a result of the variety of opportunities that were provided by bringing 10 or 12 agencies under one roof and the critical mass that was created by doing that. I have every confidence—and it is not romance—that the same will happen to a great extent as multiservice agencies are created.

With respect to the insured services, I wanted to point out to Mr Jackson that those insured services are provided where they are available. They're not now available, with consistency and equity, across the province, and that has been the decision of whatever government, as to whatever funding has been put into the provision of the services, and they're provided only under the Canada Health Act in one province of Canada: New Brunswick. This legislation lays out a long list of requirements to be provided through multiservice agencies that I think will be an incredible improvement in the volume and quality of service provided over the current legislation.

The Chair: Excuse me, Madam Minister. Mr Wilson, you just had a question on that?

Mr Jim Wilson (Simcoe West): I just wanted to raise a point about the minister's premise about reform to date. If she'd like to finish her comments, I'll just raise that point while we have the opportunity.

Hon Mrs Grier: With respect to the specific issues that Mr Malkowski raised, I have to say to him that the integration of disabled children into the long-term care system is not something that is happening as a result of this legislation. Responsibilities for children still primarily lie with Community and Social Services, and those agencies working with multiservice agencies and benefiting from them is something that I think will evolve over time but is not part of this particular thrust.

The question of representation for the disabled is something about which I have been particularly pleased to note, as I've met with district health councils and their long-term care planning committees, the number of people with disabilities who are today involved in the planning and in the discussions and preparation for the development of multiservice agencies.

The act and the amendments with respect to DHCs specifically provide for the minister to make the nominations to DHCs, as they always have, and to ask the DHCs, as they make nominations for members of their boards, to look at the diversities and all the people in their community, and specifically in the designation of a multiservice agency to reflect the diversity in the community.

I see this as moving us some distance towards full recognition and integration into planning and into the management of the system of people with a diverse range of needs across this province.

Your point about the acknowledgement of the prevalence of hearing loss in seniors and the need for multiservice agencies to be sensitive to that is one well taken. While it is not something explicit in our policies and programs or in the legislation, at this point, it's certainly something I will take back to the ministry.

Let me say, with respect to the member for East York, that when others ask for examples of communities that are coming together to do the planning in preparation for these changes, East York is a first-rate example. With the support of the member, I know the agencies there, which already had integrated homemaker and were the only community in Metro to have integrated homemaker before the expansion this year, are well poised and discussing between themselves and the DHC the potential to be an early leader and to demonstrate what a multiservice agency can do and the enhancement of services it will provide.

I thank the members for their questions. I know I've only touched on the surface of them, but I certainly will be following with interest the ongoing discussions. Both ministry staff and my colleagues on the committee will I'm sure be able to address these questions in further detail as time goes on.

The Chair: Thank you, Minister. Mr Wilson, one last question and then we'll move on.

Mr Jim Wilson: I've paid a great deal of attention to what the minister said in the past few minutes. I just want to inform the minister that I slipped out to attend the Catholic Health Association of Ontario's press conference just down the hall.

Minister, you've made a great deal of hay out of the fact that large sums of money have been transferred to the community-based sector and to long-term care. I think your government takes a great deal of pride—I would say unjustified, but you claim pride—in the reform of the long-term care system's that's occurred under Bill 101 and that's about to occur under Bill 173.

I just want to quote for you Sister Alice McEvoy, who's the executive director of Marianhill Centre and chair of the Catholic Health Association of Ontario task force on long-term care, because I think Sister McEvoy very succinctly summarizes where a lot of these concerns are coming from. That is that there's a great deal of distrust out there about this reform process. Here are a couple of paragraphs from her remarks at the press conference:

"When it introduced this legislation"—referring to Bill 173—"the government promised that it would produce greater access and better service to consumers. These are the same promises it made during the debate on the reform of institutional long-term care last year," referring to Bill 101.

"Let's review the results of that reform: fewer beds, less funding, less staffing and a 47% increase in the cost to consumers. The government promised more money to the program and to provide services to match local needs. The only new money came from the pockets of our residents and services were provided up to a dollar level, having little to do with an individual's needs.

"In light of this experience, we find it difficult to accept bland assurances that this bill will fulfil the government's promises."

These are very strong words from Sister McEvoy. Her concerns are reflected by almost every group that we've been talking to in the past several weeks, not only about Bill 173 but about the so-called reform that's occurred to date.

The Catholic Health Association, Minister, goes on to very clearly talk about loss of consumer choice in, again, very explicit language and charges your government with wanting to "eliminate all the charitable community non-profit agencies, and replace them with large, impersonal regional bureaucracies." They also point out the cost of MSAs and come up with an estimate that the 20 or so proposed MSAs for Metro Toronto alone will add an additional \$7 million worth of bureaucracy just to provide nursing services.

I wonder if you have any comments, Minister, because these are very strong charges coming from an extremely reputable association in our province.

Hon Mrs Grier: They are, and I certainly regret that that perception exists. I think the amount of additional funding that has been provided speaks for itself. I'm certainly prepared to lay out in detail what I've already laid out in estimates about the additional spending that has occurred on long-term care, both on the institutional side and, as I've enumerated here today, on the community-based side.

I think the placement coordination has in fact increased access to services and has done it in a way that is sensitive. I have certainly heard, and there have been many letters to me and anecdotal reports and certainly stories, about people who benefit from placement coordination, as opposed to being on eight waiting lists for a home for the aged or a nursing home, who are enabled, through placement coordination, to have a placement that both meets their needs and if, in an emergency, they have to go to a home that does not meet their needs, because that's where a bed is available urgently—the fact that placement coordination services maintain the file and assume responsibility to make a shift to a culturally appropriate nursing home is an innovation that does not exist where placement coordination does not exist.

I will certainly look with interest and be happy to speak to the Catholic Health Association, as I have on a number of occasions, about its concerns, but I hope that, through the course of these hearings, some of the misconceptions that are out there and that have perhaps been fostered inadvertently by some of the questions or concerns that others have raised can be addressed and the real picture of the enormous, long-overdue expansion of long-term care in this province that is taking place under our government and that this bill confirms and directs will truly become obvious to all, because I think that's what will happen.

1120

Mr Chair, I'm afraid I'm going to have to leave after that.

The Chair: I'm afraid the minister has stayed 20 minutes beyond when she had indicated she would leave. Thank you, Minister, for coming before the committee. I'm sure that these questions and others will be brought to your attention and we'll be returning to them.

Hon Mrs Grier: I suspect the same questions will be raised many times. Thank you for your hearing.

The Chair: Thank you. We have about 40 minutes until noon. Mr Quirt, approximately how much more time did you want in terms of other points to raise, or did members simply want to get into more questions? Did you have a number of other points when we altered the schedule?

Mr Quirt: I could complete my presentation probably in about five minutes, but I'm at the pleasure of the committee.

The Chair: If it's agreeable to the committee members, could we do that? Then we'll go back to any questions or comments from members, if that's all right.

Mr Jackson: Could I ask why the materials that are in the binder are very much reflecting the sorts of comments that Mr Quirt's been giving us? I'm just wondering if we could get into some questions, because I sense a lot of similarity in the presentation from the minister and Mr Quirt.

Mr Jackson: Are we scheduling any additional time with Mr Quirt before the committee or will we be able to continue much in the fashion we did with 101 where, from time to time, Mr Quirt was asked to come forward to clarify points?

The Chair: I think we will do that, but we also have some flexibility. I want to discuss that with the subcommittee later, in terms of some other time. With that then, perhaps I could revert to the question list that I have.

Mrs Yvonne O'Neill (Ottawa-Rideau): I object to that. I think that Mr Quirt is giving us examples. These are examples that he has given in the community. We haven't heard them. For five minutes, I think it's worth getting the acting director's presentation.

The Chair: Okay. Then if I look at heads, we'll return to Mr Quirt. If you would complete your comments, then I'll revert to the question list that I have.

Mr Quirt: Thank you, Mr Chairman. I'll try to do so as quickly as I can.

I spoke before about some tangible improvements in the system made possible by this bill for consumers and volunteers, and I talked about the provisions of one-stop access. I talked about the improvement in the range of programs and services consumers can expect to receive from multiservice agencies in the reformed system.

I wanted to very briefly talk about two other objectives of the bill and give you some similar concrete examples of how consumers and volunteers will play a more active role in the accountability relationship that multiservice agencies will have to consumers, their community and to government, and also talk about how consumers and volunteers will play a more tangible role in the planning and management of the community-based long-term care system.

The minister talked about improved and consistent accountability. I'll deal very briefly with the accountability that will exist between multiservice agencies in the province. We feel that—and certainly provider agencies have complained in the past about a myriad of expectations and rules and regulations that apply variably to community service agencies.

We are working now with representatives from provider and consumer organizations to develop a program manual for multiservice agencies that will reflect the best possible and clearest accountability relationship between those community-based not-for-profit organizations and the province, which funds them.

We feel we've made some great progress in that regard on the long-term care facility side, and I think if you were to ask either representatives from the Ontario Nursing Home Association or the Ontario Association of Non-Profit Homes and Services for Seniors, they would feel that they have contributed significantly to the new long-term care facility program manual and feel it's a much fairer representation of good practice and facilities than the government's previous policies were.

We hope that we'll be able to say the same when we complete our work with the numerous provider and consumer groups and develop the program manual for multiservice agencies.

With respect to accountability to the consumer, I think it's important to point out that consumers will have a place and a role in the actual governance of multiservice agencies. You'll see that the bill requires the minister to take into account whether in fact the board of a multiservice agency is representative of those people receiving services from the multiservice agency.

Certainly many of our stakeholders have suggested to us that the minister's policy should be to expect perhaps a third of the members of the board of directors of a multiservice agency to be people familiar with the experience of being served and delivered long-term care services in that community.

In addition, for the first time, the system will be more accountable to consumers through provisions of the bill that require agencies and consumers and the community at large to recognize certain rights that consumers have. This will be the first time that a bill of rights will apply to the delivery of long-term care community services. You'll note that a bill of rights now applies to care in all types of long-term care facilities.

In addition to that, the bill requires that consumers are actively involved in the development of their individual service plan. The bill requires that consumers, their representatives, families, have input into designing that package of services that best meets the needs of consumers. We feel in both these ways consumers have a much stronger role in the accountability relationship that exists between those agencies funded by the province and consumers, their community and the government.

With respect to planning, the minister has already pointed out that long-term care subcommittees across the province do have consumers of service at the table planning the new long-term care service system. Her

requirement was that fully one third of the people on district health council long-term care planning committees were consumers.

In the future, volunteers will continue to be involved in planning those services. While district health councils are provided with support staff, the vast majority of the work done by district health councils is done by volunteers in their community, representing various sectors but coming together to plan and advise the minister on the appropriate range of health care and long-term care services in their community.

Volunteers will continue to fulfil that role, and as is the case now, volunteers will continue to have the major role in the governance of not-for-profit, community-based long-term care programs, multiservice agencies that will not only be governed by volunteer boards of interested folk and consumers but will be accountable to a membership of the not-for-profit organization in each community.

In summary, then, we feel that the objectives of a consumer-focused system and the objective of local community-controlled planning will be achieved through the tangible improvement of the involvement of both consumers and volunteers in that area.

The Chair: Thanks very much, and we'll start with Ms O'Neill.

Mrs Yvonne O'Neill (Ottawa-Rideau): Yes, Mr Quirt. I just have a couple of things to begin with.

I had the same difficulty as one of the other members has brought forward already of the unrealistic expectations when you're talking about service targeting.

You're talking about lifting the 60-hour limit. Could you say a little bit more about that, because I really don't think we can talk about more and have less to put to it. I really do feel that some of the figures that have been thrown around this morning are not understood by the general public. They certainly see that in some outlying communities, as you've suggested, there is much more in the way of placement coordination, there's much more in the way of integrated homemaking, but the actual services in the home are not what some people expect.

I would like to have you tell us exactly how that decision would be made. I think it ties in with what Ms Sullivan said earlier regarding the assessment. It sounds great, but how is that step going to be made from the way things are done now to the way things are going to be done in the scenarios you have painted?

Mr Quirt: You're quite right, Ms O'Neill, that there is a finite amount of money available to spend on long-term care services in the community and in facilities, and we have not claimed that everybody's service demands will be met at the 100% level to their satisfaction. It would be misleading to suggest that.

What we have claimed is that we're making a substantial investment in both facility and the community service side, and we will provide for members of the committee a schedule of expenditures that will show how exactly \$206 million was added to the budgets of our existing long-term care facilities over the long-term care reform budget, and we will show how roughly half of \$440 million is already at work in communities across Ontario

in providing more services through home care, through home support agencies, through supportive housing programs and so on.

1130

As the minister mentioned, we're not finished yet in that expansion. We hope that over the next two fiscal years ending in 1996-97 the balance of that \$440 million, or an additional \$200 million roughly, will be added to budgets. Those specifics we can provide on a program-by-program basis.

But your point is well taken, that even with that significant investment the demands that we're facing are significant as well. We need to do our best to manage those resources in such a way that most people get the best service that we can afford under those limited circumstances. There's a great deal more money, but there is a limit to how much money there is. That's why we feel that allowing our front-line service delivery organizations to not only make the decision about who's eligible for how much but to have at their disposal a wide range of service responses within their own organization equips them to be more effective managers of that money.

There's no question that sometimes those organizations, multiservice agencies—like the home care program does now or like community support service programs do now—are going to have to say, "No, I'm sorry, you're not eligible." But for a larger percentage of the clients they'll be able to say, "Yes, you are, and we have a fair way to determine how eligible you are and how much service we can provide."

What I'd be happy to do, Ms O'Neill, is to provide you with the draft of the multiservice agency program manual that talks about service limits in terms of dollars expended on a particular client and their family, as opposed to the across-the-board cap of 40 to 60 hours that we've been working with currently, and if there are any specific questions about eligibility and who would fall into what category, we'd be happy to answer them.

To give you one concrete example, we intend that each multiservice agency would have the capacity for some clients to authorize and deliver a level of service that would be equivalent to what some people with physical disabilities get now through the attendant care outreach program, that right now is quite separate. In some communities that attendant care outreach capability will become part of the range of services the multiservice agency provides; in others we've offered consumers the right to opt out and say: "No thanks. We're not convinced your multiservice agency is sensitive enough to our needs. We'd like to continue to be funded separately." And we've said, "That's fine."

I hope I've covered the questions you've raised, and if there are ones I've missed, I apologize. I'll catch them later.

Mrs O'Neill: Thank you for helping to clarify that situation. I think the manual should be helpful. I think your remark that you stated, that people are going to have input into their personal care, also raises expectations. I think, if anything, we should be realistic and honest and

upfront about the limitations that we can provide in the community.

Mr Quirt: I think your point's well taken.

The Chair: Ms O'Neill, can I just ask, just because Mr Quirt has mentioned that he could make available the draft manual: Is that something that each caucus could have, or how big is it?

Mr Quirt: Well, it's a fairly thick manual at this point in time, but I see no reason why within a few days we couldn't have it copied for each member of the committee.

The Chair: Okay, fine.

Mrs O'Neill: I just have one other question. It has to do with the statement of the minister, which is a technical statement that she made, so I'm going to ask you. She said that 80 to 100 people are going to be, at present, involved in the direct funding for the disabled. I was quite surprised with that number. I thought it would be much higher, having been involved in the Bill 101 hearings. Is that the limitation of the pilot project, or why are those numbers so low?

Mr Quirt: It is a limitation of the pilot project, clearly, and we have taken a rather unique approach to this, in effect designing this pilot project at the table with representatives of groups of people with physical disabilities. Off the top of my head, I don't recall the particulars of arrival at that number of 80 to 100. I think it's fair to say that the disabled consumers who are helping us plan this are comfortable with that number as a pilot. Certainly, if they were before the committee, they would say that's only a pilot, and we hope that this program's expanded once it has proven its worth.

But I can provide the details of not only how that decision was arrived at, but the eligibility process that's currently under way involving organizations that represent people with disabilities in selecting appropriate pilot cases, if you like, or pilot individuals who will have the right to receive money directly from the government to hire and train and employ their own attendants. We're relying on the community of people with disabilities to help us with that selection process in, I think, five or six locations across the province.

Mrs O'Neill: Finally, the time line on that pilot.

Mr Quirt: We hope that we will be writing cheques to people this fall so that they can start to recruit them, employ their own attendants this fall.

Mrs O'Neill: But what is the limitation on the length of the pilot?

Mr Quirt: I believe the pilot, at this point in time, is scheduled for a two-year period. It will cost us a little over \$4 million a year. Both those figures are subject to my confirmation. If I've misled the committee I'll give you the exact details.

Mr Larry O'Connor (Durham-York): Mr Quirt, you suggested that one third of the representatives will be consumers. I believe that the consumer representative on the multiservice agency is going to be crucial to continuing some of the participation that we've seen in the past, the volunteer network that is out there and in the community. But when I take a look at part VI of the bill, I

guess you could say 11(2)(a) is a good definition of what a consumer would be. It's quite flexible and it doesn't point to numbers at all. You suggested one-third makeup. Because it doesn't say one third in the bill, I wondered how you'd arrived at that and if you could maybe share with the committee where that figure came from.

Mr Quirt: That's a very good question. In response to that I'd point out that the bill is somewhat flexible in that regard. We were reluctant to draft the bill in such a way that it said, "In every circumstance, in every part of Ontario, there shall be one-third consumers on the board of the multiservice agency."

As has been pointed out with some of the members of the committee already, there is a great variation in the speed at which local communities are coming to consensus about their multiservice agencies, and it may well be that in some parts of the province the minister would have to approve or designate as a multiservice agency a service provider organization that would have difficulty at first, perhaps, in meeting that one-third consumer expectation.

For example, the minister's position is that public health units or municipalities are not our first choice for multiservice agencies because they don't, in their current format, provide for that degree of consumer input at the governance level. If, for example, a community was to come forward and suggest that a hospital board or some other local organization was really best equipped in that community and the district health council had looked at all other options and suggested to the minister, "Gee, we'd like to do it the way you suggested but it isn't exactly possible right away in our community," the bill gives the latitude for the minister to accommodate that unique circumstance.

But she's been very clear, as have we through our policy documents and through statements, that a significant and meaningful consumer representation on the board of the MSA is what is called for.

Mr O'Connor: Accountability—another point. You mentioned just now local health units. I'm sure that it will be pointed out to us through the committee hearing process that local health units could provide the service; in fact, as far as representation is concerned, they report to an elected municipal council. Why couldn't they then continue to serve us and be the MSA? Perhaps you can share some of your thoughts there.

Mr Quirt: I'd be happy to. Mr O'Connor has pointed out in his remarks about the perspective of public health units and municipalities, a fairly consistent theme in that public health units across Ontario in many communities are saying, "Well, heck, we've been the operators or managers of the home care program to date and how can you be more accountable to your community than having to get elected by it?" That's a valid perspective.

On the other side of the equation, through our consultations and through the submissions of important consumer organizations and provider organizations, notably the Senior Citizens' Consumer Alliance for Long-Term Care Reform and the Ontario Community Support Association—both groups spoke very eloquently in their submissions about the importance of real consumer

representation on the board of a grass-roots, community-based organization, accountable to a membership in a broad sense as opposed to accountable strictly through the political process. Based on that advice from consumers and providers, the government has adopted a definition of, if you like, accountability to the community that's a little broader. It allows for direct consumer involvement, it allows for interested folk to be members of the not-for-profit organization that operates the multiservice agency to elect each year the board of governors or the committee of management of that multiservice agency and to truly deliver on the commitment of consumer involvement.

While that's a valid perspective that has been raised, I think in weighing the different points of view we certainly heard more often about the importance of broad-based consumer involvement in the governance of MSAs.

1140

Mrs Sullivan: There are a couple of things that I want to raise. First of all, I'm interested in Mr Quirt's discussion of the policy manual on the long-term care facilities because while his suggestion is that the homes for the aged and nursing homes see this manual as being an extremely positive and forward-looking step, I am not hearing those same kinds of responses.

In fact, what I'm hearing is that the Ministry of Health is micro-managing, making decisions and putting forward specifications including, for instance, the brand of mouthwash that has to be stocked in a long-term care facility, when in fact many of those decisions are more appropriately made at the level and at the place where they have to be implemented. That's one of the concerns that I see with respect to a program manual. I will definitely want to see not just a portion of the MSA manual but the entire manual so that we can review that while the process is proceeding.

Another issue: You speak about the involvement of the consumer in the planning and delivery and so on of care. I suggest to you that we have to remember that the consumer is the public at large in the way you're using that term. If you are speaking about the consumer as being a participant in the system itself, you will see that in fact clients aren't involved in the planning, other than in terms of their own personal file, of the system as a whole.

I would like you to comment, before you run away in about 15 minutes at the end of this particular session, with respect to the 20% provision in the act. The policy statement made by the minister earlier indicated that 10% of services could be purchased from private sector organizations and agencies. The bill indicates that 20% of services can be purchased outside of the agency, presumably not only from the private sector but if, by example, there was a service required by a client that is not included in the mandatory basket or in the services that the MSA is able to offer, that could be purchased outside.

One of the interesting interviews that I had in recent months was with representatives of the Ottawa-Carleton area who indicated that their costs in fact would rise by over \$1 million because of the requirement of the 10% rule with respect to purchase of private sector services. In

fact, what we're seeing here, if the 20% includes both private sector services that are available and other agency services, may well be an incremental cost that hasn't been fully factored.

I'd like you to comment on that: What the 20% rule means, what other services will likely be provided, who can provide them and what happens if those services are required above the 20% level to meet the reasonable and assessed requirements of clients and yet the agency has in fact met its 20% cap.

First of all, I should say that I hear your comments on the direct-funding pilot with some amusement because each time we've seen you before a committee, we are told that the funds are going to flow imminently and I think this is at least three or four years now that the pilot has supposedly been under way. I guess we'll believe you this time, but it's been an awful long time coming. You'll recall that pilot was ready to go when the last government left office.

Perhaps you can respond to those issues.

The other issue I want you to respond to at this time is with respect to the statutory requirement for employees of the MSA to deal with banking and other financial transactions of the client. I think there are particular legal problems in association with that and certainly enormous liability problems that many agencies have already faced and have been and are deeply concerned about.

The Chair: Sorry, if I could just interrupt, Mr Quirt, after you've responded to Ms Sullivan, then turn to Mr Wilson in your response, and that should bring us to the end of this morning. I would note, just because it came up, that you will be with the committee, so there will be other questions and we'll work out an appropriate way for you to be able to respond at other times to questions as we go along.

Mr Quirt: Thank you, Mr Chairman. I'll try to respond as quickly as I can to Ms Sullivan's points, and I remind the committee that my colleague Gail Czukar is prepared to provide a detailed briefing on the specific wording of the legislation and how it arrived in its present form. I feel the committee would benefit from her remarks in that regard. I'll also ask Gail to speak to the last issue raised by Ms Sullivan, the statutory requirement with respect to banking and clients and so on raised by Ms Sullivan.

If I may quickly go through the three or four things you raised, I agree with you that it's important that a policy manual reflect the different points of view of service providers and others. I think you've quite rightly pointed out that particularly from the homes for the aged perspective, some providers find our program manual and our new set of provincial expectations too specific and have accused us of micromanaging, and have for the first time really been subject to a consistent set of expectations with respect to what the province would like to see delivered in long-term care facilities.

On the other hand, the nursing home program would see the current program manual as building on the compliance program manual previously developed with nursing homes, with their input. Certainly, when we pull

our program manual committee together, which not only has representatives from the nursing home association and the homes for the aged association but people from Concerned Friends, from labour organizations, from the Ontario Association of Residents' Councils and from the Advocacy Centre for the Elderly, there is often a difference of opinion in how specific the province should be and the degree to which the province is responsible for safeguarding the interests of residents in those facilities. I think it's fair to say that sometimes the provider perspective and the consumer perspective differ in that regard. That's why we want to balance all those perspectives and hope that our standing committee to improve the manual will do that.

Secondly, I would agree that the multiservice agency should be accountable to the public at large as well as to the consumer. We hope that a balance of perhaps one third consumer representatives and two thirds from other interested folk in each community will provide that variety of perspectives and hopefully lead to good governance that's really reflective of community wishes.

You asked specifically about the 20% rule and the former 10% rule. You will recall that during the early developmental stages and expansion of the long-term care system, as we invested a couple of hundred million dollars in the community, we did have an expectation that over time, home care programs would alter their purchasing practices so that they would achieve a 10% maximum purchase of commercial services overall.

We listened to our planning partners, not only district health councils but agency representatives as well, and recognized there had to be a closer link between the achievement of our multiservice agency program objectives and the achievement of the government's objective of not-for-profit service delivery. As a result, we've replaced that 10% expectation with the provision that you see in the bill, which is an expectation that multiservice agencies will buy, in each of the categories of service, a maximum of 20% of service from outside agencies.

1150

We felt that we had to stipulate a percentage of service that MSAs would deliver themselves in order to achieve the benefit of the integration of case management and eligibility determination on the one hand, and service delivery on the other. If the bill wasn't specific in saying the majority of services has to be delivered by the MSA, we may never move away from the brokerage model, and it's precisely the move away from the brokerage model that consumers are asking us to make and that the Ontario Community Support Association, representing 400 volunteer-based organizations and more, is suggesting we make.

The 20% would apply as follows: For example, in the area of homemaking, the multiservice agency would be expected, in its complete and full version, to purchase only 20% of its homemaking services from outside agencies. That would allow for the continued purchase of some services from the commercial sector, particularly in those cases where a particular client had developed an affinity or a long-standing relationship with a particular worker who didn't become part of the MSA and was still

involved with a commercial agency. The 20% purchase limit would also allow for just the situation that you pointed out, Ms Sullivan, where you pointed out that sometimes with a very specialized service, it wouldn't be appropriate or economical to have a highly specialized professional in the employ of the multiservice agency. It could be that, for example, a psychiatric assessment or a psychological assessment might be purchased, and that 20% would allow for that, or particular services of professionals.

The four-year exemption period is designed to allow some flexibility in achieving that, and for example, the 20% rule is one of those rules that the minister can grant an exemption about. So if, for example, in a particular community a not-for-profit homemaking or a nursing organization needed time to plan its transition into the MSA, in effect 70% or 80% of the nursing service might continue to be purchased for the first year, and then that would go down the second and the third, and it will allow for a more orderly transition to the integration of eligibility determination and service delivery.

I'm sorry if I've taken too long and too much of the committee's time on those answers.

Mrs Sullivan: No, that's fine. Just on that, that ministerial exemption is only in place for four years, for an absolute maximum of four years.

Mr Quirt: For up to four years, that's correct.

Mrs Sullivan: If at the end of the four-year period there is a client population of the MSA which requires services that the agency is not able to provide from within and that agency has already reached the maximum of 20% of purchased services, the client will therefore go without because there is no exemption and no opportunity for exemption after that point.

Mr Quirt: I would suggest to you that the minister, in granting the exemption for the four-year period, would be asking for a plan for how the organization, the MSA, would over that period achieve the mandate prescribed by legislation to deliver those full range of services, recognizing that the agency has at its disposal the capacity to buy 20% of the services in each category and, secondly, recognizing that any purchase that's made from another MSA that may have that specialized service you're talking about doesn't count towards that 20%.

For example, if a particular multiservice agency among the 15 or 20 recommended for Toronto had a specific capacity to deliver services in a very culturally or linguistically appropriate fashion, it may well be that somebody in Durham region might say, "Heck, for this family of Italian origin, I think we may in this case decide to purchase services from the MSA that's our neighbour that is particularly good at that." That doesn't limit their ability to spend 20% in other circumstances.

I'll ask now that the last question, Mr Beer, if you don't mind, be addressed by my colleague Gail with respect to the statutory requirement.

Mr Jackson: Mr Chairman, I would like to put this request for information for the record, since both legal counsel and Mr Quirt will be touring the province with us on this bill. If I could serve notice of these additional

questions, that might be helpful. Could I get a list of the current MSAs which are filed with the ministry or the minister and the locations of those MSAs? When we're in a given community, it would be helpful to committee to know, when we're listening to deputations, what the nature of the formal consultative process has produced in that given community.

The minister mentioned 13 homes for the aged with upgrades. Could we get a list of those and their location and where the moneys were coming from, because I suspect that is very much like peeling an onion where we're going to find the funding if Jobs Ontario has gone into a given facility, and what is its impact on the number of beds because in some of these, I know, as a prerequisite of an upgrade they had to reduce the number of beds. I think that's very helpful to the committee. If we're in a community during the course of these hearings where they've actually lost institutional beds, we'd like to know that.

The third question has to do with the matters with respect to the amount of moneys which the government is free-floating to homes for the aged and nursing homes as a consequence of the scheduled residential fee restructuring which occurred July 1, was it, of 1993.

My last conversation with Mr Quirt was that the province is subsidizing the loss of revenue from residents who are unable to pay the rate or where the facility cannot offer them less expensive accommodation. I would like to know what cost is currently coming out of this budget, and in estimate terms, what panel you may have budgeted from that you're borrowing from in order to make those commitments. I know that was not a budgeted item but that they're coming from some other budget, and we'd like to be able to determine if it's come out of somewhere within long-term care or if the minister has some \$70 million float fund that she can work with on this one.

I'm sorry, just for the record, do we have the regulations now in place for Bill 101? I'd like to know if that's a yes or a no.

Mr Quirt: That's a yes.

Mr Jackson: Could we get a copy of those regulations—

Mr Quirt: Yes.

Mr Jackson: —with respect to 101, because we have yet to see those, those of us from the committee who participated in 101.

The final question: Are there any services or procedures that are being anticipated in the new manual as a result of Bill 173 that are missing from what we are currently, or have been working with, up to this point? Any procedures, any services, any levels of service or level of procedure which have been removed? I'm talking about if certain support services are now—because unless that's monitored, they can just sort of slip away, because it's all done in a regulatory fashion. It's not anywhere in this legislation. What is the final status of any regulations with respect to the current bill before us? Who is drafting those and when might we have an opportunity to have a look at those?

Mrs O'Neill: Mr Beer, may I ask, are the regulations complete now? I know in this particular bill they've been released in sections. The Gazette's been bringing them forward in different groupings. Are we going to get a complete set now? Is that process complete?

Mr Quirt: The regulations for Bill 101? There may well be regulation-making powers in Bill 101 that we haven't exercised yet, but yes, there have been a number of regulations that have been made and passed.

You'll note that some of the sections of Bill 101, the majority of them, were proclaimed July 1, 1993, and some remaining sections were proclaimed July 1, 1994. What we can provide the committee with is a list of the things that were proclaimed July 1, 1993, what was proclaimed in 1994 and when each regulation came into effect.

Mrs O'Neill: That would be helpful.

Mr Quirt: There may well be some regulation-making power that might be exercised in future, so I wouldn't say that they were all done at this point.

I'd be happy to provide the material Mr Jackson requested, with a couple of modifications, if I might inform the committee about it.

The only formal submission that the minister has received yet on the creation of multiservice agencies has been from the Metropolitan Toronto District Health Council. As the minister mentioned earlier, we'd be happy to provide you with that material and the minister's response to the district health council in that regard.

I can think more about ways in which we could apprise the committee of the status of particular planning in each community as we travel there. I wouldn't want to steal the thunder of the district health councils which may well be coming to apprise the committee of just that, and certainly many presenters will provide that update, but we will try our best to respond to particular questions in that regard.

We'll be happy to provide the home for the aged information specifically. We'll provide exactly how much of the resident revenue we expected to receive or predicted we'd receive that has been made up from provincial funding for the previous year.

I can respond now to say that there is no service now provided by the home care or the VON or any other agency that we anticipate deleting. We are exploring the addition of some services through both our quick response team programs and our hospital-in-the-home pilots. So we're looking at ways in which it might be increased. I'm not aware of any decrease proposed.

1200

The Chair: If we could then just have the response to Mrs Sullivan's last question, and then I want some time for Mrs Sullivan, who will be the last questioner this morning.

Ms Gail Czukar: Just before I address that, I guess I regret that I haven't had an opportunity to make a presentation on the bill itself. The minister had asked that the technical briefing include a briefing on the bill, and I know that in Bill 101, during the hearings, we encountered some misconceptions on the part of both presenters

and committee members about what the bill actually said and how it accomplished certain goals. So I'd just like to say that I'm, of course, at your disposal with respect to that briefing and prepared to make it.

The Chair: If I might comment on that, I noted earlier on that point, the subcommittee will be meeting and I think that will be one of the things we'll talk about. I think it's clear in the discussion this morning, and as we found with Bill 101, that at different times in the committee's hearings it was useful to just sort of stop and try, with ministry staff—yourselves and others—to go back over a number of points. We'll have a look at that one and try to make sure that we have a means of doing that.

Ms Czukar: Okay. With respect to what Mrs Sullivan has referred to as the statutory requirement to deal with banking or financial transactions, I'm going to have to ask her where she sees it. I don't see it. We didn't intend to put that in there. The only place I can see it is the requirement—it's not a requirement; it's part of the definition of "homemaking services"—that one of the services that could be made available and is available to people now is assistance with paying bills. Is that where you see it, or is there some other place in which you see a requirement that MSA staff deal with banking and financial transactions?

Mrs Sullivan: I believe that's the section it's included in, and banking is specifically delineated as one of the responsibilities of community services. Here it is in section 2, subsection (5).

Ms Czukar: Right. Okay, that's where it is, in the homemaking: "banking" and "paying bills." The requirement there is that that kind of service be made available as part of homemaking services. It's my understanding that those are the sorts of things that homemakers now do and assist people with. This is simply, as with most of these items in the definitions in the bill, delineating what the services are that are to be provided and assisted with. If there are problems with those being done now—

Mrs Sullivan: There are.

Ms Czukar: —we'd certainly be prepared to hear about them.

Mr Jim Wilson: I'll try to be quick. Concerning the 20% rule—20% of approved budget—and the requirement that approved agencies meet this rule, as delineated in section 13, I just want to ask Mr Quirt, because I'm very worried about consumers in this case.

One of the services or section of services that comes under the 20% rule is obviously professional services. That includes nursing. What if a consumer, an elderly person, for example, needs nursing on a priority basis, urgently, yet that agency has capped out already at its 20% ceiling? How does one control this?

For example, is it going to be like the bloody drug program that your ministry tries to run, where the prior approval process takes six, eight weeks; four, five, six months? I've got letters in my office that haven't even been answered in six months, let alone the drugs approved. How are you going to monitor this 20% rule—that's the first thing—and ensure that consumers get the services they need right away? I'm ruling out, here, Mr

Quirt, that you can easily purchase from the agency next door, because it's hit its 20% rule, to take the worst-case scenario.

Secondly, I'm extremely upset, and I guess this is more of a policy question that probably hits the political realm, that we see the 20% enshrined in legislation. It makes it very difficult—this government is not going to survive many more months—for any future cabinet to introduce some flexibility in this section. We would have to go back to Parliament, whereas in Bill 101 we were able to have cabinet deal with the 10% rule because it was simply a policy statement by the government itself. I want to know what the background was in coming up with a legislated 20% rule, which I think will hurt consumers in this province.

Mr Quirt: If I might respond to your first question, in the event that a multiservice agency had a so-called run on nursing services, if a number of clients appeared who hadn't been planned for, who required extra nursing service, it was our intention to allow that 20% purchase to deal with those types of fluctuations in demand. In other words, from the 20%, the MSA would say: "Well, gee, we hire and employ 20 nurses. I guess we'll contract for three or four additional clients, because it looks as if that's kind of a blip, that we won't have an ongoing need to serve those extra clients."

My response would be that if that became a trend, that this amount of nursing service became the normal volume for the MSA, they would simply hire another nurse or offer the job—you know, advertise it or offer the job to one of their other agency partners' staff in the community.

How would we monitor it? Each year we hope to enter into a service agreement with each multiservice agency that would document what the province's commitment was fundingwise in terms of the eligibility of that particular community for funding, and the multiservice agency would document the level of service outcome that the people of Ontario could expect in return for that money. In that service agreement, there would be a negotiation process that would agree on how many nurses should be employed in the first place, depending on how much demand there was the previous year, and hopefully with some latitude in that to allow for additional purchases in perhaps peak periods, Christmastime or whenever the community service system is called upon at a higher level than normal, to accommodate those shifts.

But it would take some planning ahead of time and you've got a point: If somebody is at their 20% rule limit and somebody needs to be served, then the agency is either going to have to ask us to go over for that particular month and make it up later or they would ask us for quick approval to hire another nurse or would have that approval already in the service agreement.

Mr Jim Wilson: There's nothing quick about approvals in the Ministry of Health, is my point.

Mr Quirt: I can't speak to your experience on the drug program, and I'd be happy—

Mr Jim Wilson: Or anything else.

Mr Quirt: —to refer any particular problem you have

there to the right official, but I can say that most of our community service agencies that we deal with do find a reasonably quick answer to many of their policy or operational questions, given the fact that our division is equipped with decision-makers in 14 communities across Ontario, as opposed to every question coming to Queen's Park for an answer. I suspect that when you hear from—

Mr Jim Wilson: But this is a statutory ceiling.

Mrs Sullivan: Statutory: They don't have any power.

Mr Jim Wilson: Your person in the field, unless it can meet these exemptions, which are also statutory, doesn't have that flexibility. The MSA police in the field can't decide whether to issue the ticket on the side of the road or ignore the violation; this is a statutory requirement, unless you're suggesting you're going to be in breach of Parliament. Then we can get into all kinds of niceties about that.

Mr Quirt: I'm not suggesting that our staff would propose to multiservice agencies that they don't follow the law. I am suggesting that they'd be involved in discussions throughout the year in a service planning process that would agree on a contract from year to year, and that my staff would be expected to say: "Hey, wait a minute, what happens? You should employ another nurse, because if you hit a high period six months from now, you might be too close to your 20% limit. Why not hire a couple of nurses and bring it down to 3% that you purchase so you've got some latitude?"

It would be that kind of discussion and negotiation that I'd expect the public would want their public officials to engage in to ensure that the bill could be followed and that service, as a result of the bill, would not be jeopardized. I can't argue with the theoretical situation you have described. If some agency is about to break the law on the service delivery side of it, then obviously we'd be working with the agency to figure out why they got themselves in that position.

The Chair: I'm going to have to cut us off at this point.

Mr Jim Wilson: Could I have an answer to the second question? I'm sorry for prolonging this.

The Chair: I would ask the parliamentary assistant to respond to that.

Mr Jim Wilson: Yes, it's probably better in his realm. We thought it would be interesting.

The Chair: It's just that it's after 12. We do have a set of weeks ahead of us and we will be able to return to some of these questions. I just feel that after this we need to move on.

Mr Jim Wilson: Could I just thank Mr Quirt for answering the question, which was no doubt difficult.

The Chair: You may, and just before Mr Wessinger answers the second question, can I note again that I need to see the subcommittee briefly at the conclusion of this meeting.

Mr Wessinger: I'll be very brief, since we have gone over the time. I'll just reiterate what the minister said when she indicated that it was a policy decision to ensure that we had a service delivery model for the MSA where

you had the assessment and the delivery of service primarily with the MSA, and pulling the 20% as a figure that was felt would achieve that end.

Mr Jim Wilson: Given that it was 10% and now it's 20%, it seems to be a fairly arbitrary figure, and rather than putting it in a regulatory-making section, you're putting the figure 20% in this legislation. On what basis do you come up with that figure, Mr Wessinger?

Mr Wessinger: I can't give you an answer of how the particular 20% was arrived at, but I could indicate that certainly it's the intention to have a legislative model that can't be converted to a brokerage model. I think that's basically the intent behind the legislation, to ensure that it preserves the model of the integration of the service delivery and the assessment and not that it could be converted to a brokerage model type of service delivery without change in the legislation.

The Chair: With that, then, we will complete our morning's hearings. I know that we will be—

Mrs Sullivan: On a point of order, Mr Chair: Could I put another question on for the ministry officials? I think that as a result of this last question and other questions that have come up, it's very clear that we have deep concerns about funding, and the response to the last question has even added to my unease with respect to the funding.

First of all, I think it would benefit the entire committee if we learned what the ministry contemplates in terms of how MSA budgets will be determined. I am given enormous pause by the suggestion that the budgets will be negotiated with the personnel in the 14 regional offices. It is very important that we know what needs-based planning is going to go into the budget preparation, if in fact this becomes an across-the-table negotiation, if the MSA has determined a level of need for services in a community, is attempting to meet the statutory requirements as well and if one of the 14 regional people or somebody in downtown Toronto MOH offices says, "Yes, you have to provide this, this and this; this is required under the law," but you don't have the money to do it and the budget request that you've provided doesn't cover those needs. I think we need a full briefing, and frankly I think consumers do too, because consumers are being led down the garden path on this.

The Chair: We'll add that question. As I said before, I think we will need, throughout these hearings, to just create some time where we can come back to some of these questions.

With that, then, the morning's proceedings come to an end. We'll begin again at 2 o'clock sharp here in this room. Thank you. We stand adjourned.

The committee recessed from 1214 to 1408.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair: Good afternoon, ladies and gentlemen. The standing committee on social development is back in session and we are reviewing Bill 173, An Act respecting Long-Term Care.

We will begin our afternoon submissions by hearing from the Registered Nurses' Association of Ontario, if the representatives from the RNAO would please come

forward. Members should have a copy of their submission. We welcome you all to the committee, if you would be good enough just to introduce yourselves for Hansard, for the committee members, for the great television audience that is out there. We look forward to your submission, and at the end of it I'm sure there'll be some questions.

Ms Kathleen MacMillan: Good afternoon. I'm Kathleen MacMillan. I'm the president of the registered nurses' association.

Ms Johanne Mousseau: I'm Johanne Mousseau. I am a member of the Registered Nurses' Association of Ontario.

Ms Margaret Watson: I'm Margaret Watson. I'm the executive director of the registered nurses' association.

Ms Jacqueline Choinière: I'm Jacqueline Choinière. I'm the nursing practice and policy coordinator.

The Chair: Welcome.

Ms MacMillan: The Registered Nurses' Association of Ontario is pleased to have the opportunity to speak to the standing committee about this most important legislation. The registered nurses' association is a professional association representing approximately 13,000 registered nurses who work in a variety of community and institutional settings. Many of these are in long-term care.

The framework for our response is the government's long-term care objectives: objectives which we strongly endorse and that we, as registered nurses, are committed to realizing.

Objective 1: the issue of one-stop access. The move to simplify access by Ontario citizens to long-term care services is an important objective. Current services are often fragmented, confusing for clients and their families, and too often result in unnecessary delays in attaining needed care. The principle of one-stop access through MSAs can be a step towards ameliorating this confusion.

As registered nurses, we realize that the client's initial contact, by phone or in person, is but one half of the access equation. The events that follow first contact are equally important in ensuring appropriate access. Appropriate assessment and screening must be available to the client in need. This initial assessment becomes even more critical in a streamlined system; it may be a client's only contact for weeks. Although assessment tools are valuable, there are many situations in which the tool alone is inadequate without a skilled assessor who has the knowledge base to critically appraise each client situation.

I'm going to give you an example here. The daughter of an elderly woman who is able only to visit her 84-year-old mother irregularly because she lives out of town might notice that her mother isn't keeping up with her personal hygiene, housework or food shopping. In this situation she would be placing a call to the local MSA for assistance, and a standard assessment might be carried out and a decision made to send in a homemaker two days each week for a total of six hours. The homemaker can do the shopping, the housework and assist the lady with her bath.

On her next visit, the daughter would probably notice that things look better. Mother doesn't have as much

energy as she used to have and she sleeps more and her appetite is poor, but, according to the usual myths, the daughter figures it's because she's 84. The homemaker can go ahead and notify the pharmacy when the medication supply of digoxin and Lasix runs low, and the lady is not due for another medical assessment for two months.

What the daughter doesn't know is that her mother has been self-medicating for constipation by taking Ex-Lax on a daily basis. Her potassium is seriously depleted, she is digitalis toxic, she has an irregular heart rate and is a high risk for a cardiac arrest. Her underlying problem is poor bowel management, which is easily corrected with diet and certain over-the-counter medications. What will probably happen is a major cardiac event and an emergency hospital admission, followed by fairly intensive medical care. She'll probably likely experience further deterioration and also become a placement problem.

What should happen is an initial nursing assessment, an assessment that includes a full functional health inquiry and risk assessment. The nurse can then alert the homemaker regarding warning signs and symptoms, and the homemaker also has a nurse contact within the MSA whom she can consult if the client's status changes. In addition, there could be regular client review meetings within the MSA between the relevant care providers and professionals.

We therefore recommend that registered nurses, who are educationally prepared to play multiple roles in the system, be utilized in the long-term care setting as assessors, care providers, coordinators, educators and resource planners.

The changes in the long-term care system outlined in this legislation constitute a radical shift in the coordination and delivery of long-term care services. Described in this legislation is a transformation from a traditional, hierarchical, complicated system to a more democratic, accessible and simplified system. Although in principle these are welcome changes, there is a need to provide adequate education about these changes to clients and to potential clients. The public must be adequately informed about which services are available, where these services are available, who performs the various services and how these changes have been incorporated.

In addition, health care providers will also require comprehensive and ongoing education about these system changes so that they can let clients know about their existence.

We therefore recommend the development of educational plans for public and long-term care providers in order to ease the system transition and avoid interruption in needed care.

Objective 2: improved community-based service system. In order to achieve and maintain improved community services within an increasingly complex and diverse system, we believe it is essential that services be coordinated by health professionals with expertise in health promotion, illness prevention, managing the full range of care options and evaluation. Long-term care is built on a strong foundation of nursing research and practice, from which nurses and other providers draw

their knowledge. We are concerned about the deprofessionalization of services: services delivered by non-regulated workers, such as personal support workers and homemakers, without the leadership of nurses in the community. The services that these support workers provide can be safely delivered when the client is well informed about his or her health condition, can direct the care and only needs the provider to meet the directed needs.

The frail or the cognitively impaired elderly person, for example, is a much different consumer of services. Their physical health is more fragile, less predictable and more complex. They may be unable to advocate on their own behalf and may well require professional nursing services, if only as a resource to other direct care providers.

Even care as apparently straightforward as personal hygiene is an integral component of comprehensive nursing care as a vehicle to assessment. If we are to truly realize holistic care, then we must not subdivide the care of individuals into separate, isolated tasks. A devaluation of both client and care provider is the result.

We therefore recommend that the same principles underlying the integration of health and social services be applied to ensure the healthy coordination and integration of providers in long-term care settings.

The skill and expertise of the registered nurse promotes earlier identification of client problems, complications or treatment side-effects. This in turn is likely to result in more timely treatment alterations and a better informed, more satisfied and healthier client. In addition, the health care system may be spared the cost of emergent or urgent treatment intervention because earlier symptoms or needs were not identified. The less costly provider may not in certain circumstances be less expensive in either human or financial terms.

We therefore recommend the inclusion of a well-defined system for assessing clients which health administrators and managers will utilize when identifying the right provider for the right service.

Objective 3: a consumer-focused system. As registered nurses, we support both the letter and the spirit of the bill of rights for consumers receiving community services. However, we believe that the rights do not fully address the need for clients to be fully informed about their health condition and the implications of specific care on that condition. It has been our experience that when care is reduced to a series of tasks, essential information is not exchanged and the client fails to receive comprehensive care.

I'll give you another example from clinical practice. An 18-year-old male with Duchenne's muscular dystrophy is living at home with his mother and a much younger sibling and is now ventilator-dependent at night because of sleep apnea. His mother is responsible for his care at night, which includes getting up with him at least once and also generally listening for the ventilator or other problems. She also works full-time outside of the home during the day and has frequently become exhausted and had to arrange for respite care for her son.

His illness is chronic and long-term but will eventually be fatal due to cardiac failure. Until turning 18, he had

access to a full range of professional services, including a visiting registered nurse, a school RN and a respiratory therapist. Suddenly, at 18, he is considered able to direct his care with the aid of a personal support worker, a change which he views as enhancing his autonomy.

This situation demands more, however, than the services of a personal support worker to provide physical and emotional care and assistance with the activities of daily living. The complex family situation, the needs of the care giver mother and the sibling, plus the effects on their health, all need to be considered. This young man is medically very fragile and he needs regular assessments and early problem recognition to prevent complications.

Who decides on the most appropriate provider? The personal support worker needs a clear reporting mechanism and adequate instruction and supervision. The situation is not just a single person who cannot meet his own daily needs, but a constellation of complex issues needing professional health services. Fragmentation of care will have disastrous results for the client, the family and the system.

We therefore recommend that the bill of rights be strengthened so that the right of clients to full and comprehensive explanations of their conditions and the implications of specific treatments is underlined.

The impetus for long-term care reform has been largely driven by the well elderly and the well disabled in the community. As registered nurses, we have long advocated for the right of clients to fully participate in decisions about their care. Those needing long-term care services have not been well served under the present delivery models, which denied them control over the nature and the selection and delivery of support services.

However, missing from the planned reforms is attention to the largely silent voice of the sick in the community. The documents on long-term care do not reflect the needs of vulnerable populations such as the frail elderly, the cognitively impaired or their families. The words "nurse" or "doctor" rarely appear in any of the long-term care reports, reflecting the focus on those who are able to direct and access services relatively independently.

1420

While persons have relatively unfettered access to physician services, access to nurses in our health system is highly problematic unless the client can afford to pay direct on a fee-for-service basis. Access to insured nursing services is dependent on admission to a hospital, a nursing home or a long-term care facility; referral on discharge from such a facility; or a medical referral in the community. This is an unnecessary, complex and expensive method of accessing nursing services. It requires the potential client to enter the system by the most expensive route and often the least appropriate route before finally seeing the correct provider for the problem.

Again I would like to invite you to think about an actual example. An otherwise healthy 90-year-old woman living in the community with her daughter experiences a sudden onset of acute illness with nausea and vomiting. Her daughter calls the family physician, who doesn't make house calls and refers her to a doctors' house call

agency where the woman is able to get a doctor to visit.

He diagnoses acute constipation and prescribes a suppository, which the daughter is asked to purchase and administer. The cost is \$50 to OHIP and no cost to the client, but there's an incomplete outcome. Because of lack of experience, the daughter doesn't know how to give a suppository, but fortunately has access to a neighbour who is a nurse. The nurse is willing to provide one hour of nursing services which include a complete assessment, administration of the suppository, comfort and hygiene measures and teaching to prevent another episode, plus an assessment of the outcome. The cost is \$30 in time to the nurse, no cost to the client.

It is also relevant to our presentation that nurses have been subsidizing the health care system by providing free services in their communities, where needed, for decades. If the nurse had not been available, where would the daughter have turned for help? Even if the daughter had known to call a visiting nurses' agency directly, she would have had to pay for the service out of pocket.

Sometimes people need a nurse, not a doctor, but they cannot access one. If this daughter had subsequently taken her mother to a hospital emergency department, she would have seen another doctor, undergone a full range of medical tests, laboratory tests, possibly abdominal X-rays, been diagnosed finally with constipation and ultimately she would have been referred to a nurse in the emergency department for treatment. This, I would estimate, might have cost \$600 to the health care system.

We therefore recommend that long-term clients have direct access to professional nursing services when this expertise is required.

Objective 4: improved and consistent accountability. We strongly support the need to ensure that the composition of the MSA board reflects the community that it serves. However, in order to enhance accountability, we believe that this issue deserves stronger assurances within the legislation. Culture, gender, age, language and differences in ability fundamentally influence every aspect of care assessment delivery and evaluation. We would also recommend the addition of economic status to this list of critical variables.

Health and social service providers possess expertise that is critical to decision-making at the MSA level. Registered nurses have demonstrated the strength in community programs and are knowledgeable and effective in creating linkages between individuals and also between the individual and the required service. Nurses have a long history of being especially effective in development and implementation of programs designed to meet the needs of the economically disadvantaged, those most likely to experience both acute and chronic ill health.

The legislation is unclear about how the MSA board will actually be selected. Furthermore, what role will the community at large play in selecting the service delivery models? How can we assure that community members are effectively involved in this process? Will town meetings or other types of community forums be held?

We therefore recommend the inclusion of stronger

assurances that the community at large will be actively involved in the selection of service delivery models and the MSA board members and that the board itself will include a truly representative sample of community members and the critical element of practitioner expertise.

We recommend that full and inclusive public consultations be conducted to decide on the full range of MSA services and service delivery models. We also encourage the ministry to ensure that the participation of those not traditionally included in consultations is actively sought. There is always a possibility, when services are decentralized, that inequities in service availability could result. We therefore urge the ministry to mandate a true quality assurance of services by upholding a common and province-wide standard of excellence.

We therefore recommend the assurance of high-quality services for Ontario citizens through the existence of effective standards, and we also recommend that improved and consistent accountability be enhanced through effective community consultation.

Finally, objective 5: local planning of services, We support the strengthening of the mandate of district health councils within this legislation. We are very supportive of this affirmation of local participation and planning. However, we are concerned that the DHCs, like the MSA boards, are truly reflective of the community they serve. Accordingly, we would recommend the inclusion of stronger assurances that DHCs will actually reflect their communities. We would also recommend additional assurances that DHCs will particularly seek out those in the community who have not traditionally participated.

Registered nurses have traditionally played a coordinating role among other health care providers within all health care settings, and this coordinating position finds its rationale in the fact that nurses are the only health care professionals who span the entire care continuum. As such, we consider nursing expertise to be critical in the decision-making activities around community services.

We would also recommend that the ministry ensure that DHCs have access to appropriate resources, both financial and human, in order to fulfil this very critical mandate. Valid health care planning requires ongoing information gathering and dissemination, activities requiring adequate resources.

Therefore, we recommend the inclusion of assurances that DHCs will accurately reflect their communities, with particular emphasis on those community members less likely to participate, and drawing on the special expertise of nurses from the community. We also recommend that the minister provide DHCs with adequate resources to effectively fulfil their mandate.

Some summary comments: People tend to think that the line between health and illness is clear and easily recognized. In actuality, the distinction is very blurred, more like a continuum. When persons have concurrent chronic and acute conditions, it is often very difficult to distinguish what is happening. The elderly in particular do not always exhibit the commonly recognized signs and symptoms of illness such as pain or elevated temperature. It requires professional knowledge, judgement and skill

to determine the underlying problem and to decide what needs to be done.

While the needs of the well disabled and the well elderly have not been adequately met under our current system, neither have the needs of the ill in the community. We must be careful not to reform the system in a piecemeal fashion so that reforms for one type of consumer will actually exacerbate existing problems for another.

We must also evaluate the impact of the perceived least expensive approach to service delivery. The least costly provider may not always be the most cost-effective.

We urge the committee to carefully consider the issues and recommendations identified in this submission by registered nurses in the province in order to ensure that the worthy objectives of long-term care reform are fully realized.

The Chair: Thank you very much for your submission. We have some time for questions, and I'll try to work in one from each caucus. We'll go with Mr Wilson, Mr Malkowski and Ms Sullivan.

Mr Jim Wilson: Thank you very much for appearing before the committee today and being the first at bat, as it were. It should prove to be very interesting committee hearings if the briefing this morning was any indication.

If you're limiting me to one question, I'll forget about all of your recommendations for a second other than the assessment. I know in the past, in this room even, we've talked about the capabilities and talents of nurses to carry out a full range of assessment. It came up in particular during the Regulated Health Professions Act, and again under Bill 101.

The government has set up the MSA program design assessment approach working group. Are you familiar with that group? Because I note that on the inclusion of participants in the group the Ontario Nurses' Association is there, VON is there, but I don't see a listing for the Registered Nurses' Association of Ontario.

I'm just wondering if perhaps you should be on the group, or is that sufficient representation from nurses already? Secondly, is not that group looking at exactly that: who and where the assessment should be done and to what extent? Let us know, because I'm not on the group.

1430

Ms Mousseau: The group is addressing that issue. I think there's a greater concentration on the assessment tool at the moment. The point we're trying to make is that certainly the assessment tool is a very important part of the equation, but it also requires the judgement of an individual to apply that tool. I don't think just anyone can screen someone by applying a tool when an individual calls, say, the MSA. Yes, those details do need to be worked out, and I would imagine that would be one avenue. But right now it seems that they're concentrating on the assessment form, the actual tool that will be used to assess.

Mr Jim Wilson: Do nurses have sufficient input in that process that's developing the tool?

Ms Mousseau: There is some nursing representation, yes.

Mr Jim Wilson: This is your chance to let us know if you need more nursing representation.

Ms MacMillan: I think we'd always like to see more nursing representation. We won't turn down any nursing representation. We certainly are in continuous discussion with our colleagues at the Ontario Nurses' Association, so we're quite well informed usually about what it's doing. We have opportunities to have input through our connections with them, but it certainly wouldn't hurt to have some of the expertise of members of the registered nurses' association sitting on that committee.

Mr Jim Wilson: Give me a better feel for specifically what type of model you would look for. Obviously, assessment is critical to accessing the system and to make sure you're appropriately placed in the system. It's the first step after the phone call, I would think. What would be ideal?

Ms MacMillan: We personally think that nurses are the ideal people to do those assessments because of the comprehensiveness of our practice and because of our experience and knowledge and skill in this whole area of assessing and referring people to appropriate providers. It has been part of our practice for a long period of time.

Mr Jim Wilson: In terms of structure, though, my understanding of the legislation, so far anyway, is that the assessors appear to be working directly for the MSA. I don't know whether they're coming out of existing agencies or what. You have registered nurses now working at Red Cross and VON and various agencies. It's a chance to tell us whether you think we should keep current structure or pull those people out of those agencies and have them work directly for the MSA. What are your thoughts on that?

Ms MacMillan: I work for a visiting nurses' association in the city of Toronto, and one of my difficulties as a practitioner is that the current model of insured health services, in any way, is really organized around a medical model of what is required in the way of services. Frequently a client requires nursing care but does not require the list of tasks that are identified as insured services.

When you ask, what would we like in the way of structure, I guess we'd like some kind of reassessment of how nursing services are paid for, and we would also like to have a way where the nurse can work for the client and not necessarily work for the agency. That would probably be the way we would like to see it.

I'm a little worried as a practitioner about introducing another bureaucratic level. I'm very concerned. You see, currently what happens when someone's being referred to nursing services is that they have to be referred either by an agency or a physician, so there's that. If it's in a hospital setting, there's a home care coordinator who goes over the assessment. Then it goes out to the nursing agency and there's another assessment, and often clients have four or five assessments before they're actually the recipients of nursing care.

What I am concerned about personally in my practice is that we're going to have another layer here and that

instead of having four or five assessments, we're going to have six. Then when you're in the practice setting and you identify a need for a client, who am I going to have to call? What hoops am I going to have to jump through in order to get that need met?

When you're talking about structure, I would say that's probably the thing nurses are most concerned about. Is this another bureaucratic layer or is this really going to be simplifying people's access to nursing services? Right now, I'm telling you, people have to jump through hoops to get a nurse.

The Chair: Thank you. I'm afraid we're going to have to move on.

Mr Malkowski: Thank you for your presentation. Your information was very helpful, and it's valuable to have the health care professional's role involved in the long-term care.

One point I'd like to talk about is the fragmentation of care you mentioned, that would have disastrous results. What fragmentation do you see now and do you think the MSAs will resolve this?

Ms Mousseau: First of all, fragmentation occurs because you have different ways of accessing, at the moment, the health care system, whereas with one-stop access you would have one phone call to make. However, with triaging, once you've actually made that phone call, if whoever is doing the triaging at the other end is not equipped either with the appropriate tools or with the clinical decision-making abilities to determine what resources or services are required for that person, you will begin fragmenting care at that point. It's very important that the person receiving the call from the client in fact has all the tools needed in order to make the best decision for that client. That's the first point where there might be fragmentation of care.

I'm wondering if you're referring to the actual scenario we used in the presentation.

Mr Malkowski: I can give you an example. MSA is going to have a basket of services, and perhaps we could talk about the things that you may see missing. As a front-line worker, what administrative overlap could you see, for example, when you're talking about the multi-assessments with home care, with VON and with other providers? Do you think the MSAs will be helpful and do you see the RNAs having any role here in terms of exploring what gaps you see out there?

Ms MacMillan: The concept of one-stop shopping does have the potential to reduce some of this fragmentation, depending on how good the assessment is up front, and that's reiterating who's doing the assessment and what kind of tool they're using to do that assessment.

In the example we put in our presentation, the person who doesn't have a comprehensive picture of that home situation might think it's perfectly okay to put somebody in who can help this young man meet his activities of daily living and look after his ventilator, if you're really looking at what tasks need to be done here. But the nurse who might assess that would look at the whole picture, of the family, of the mother's needs and of the sibling who's trying to deal with having a terminally ill brother,

and realize that this is a very complicated situation that really does require professional services.

While it's true that this young man, when he turns 18, should have autonomy, and we're not denying that, if he also thinks that all he really needs is a pair of hands to do some tasks for him, he's not considering all the other factors in this situation. It takes a professional viewpoint to be able to do that.

What you can wind up with is that you've got somebody who does tasks, and then you'd have to call in somebody else to do another task and somebody else to do another task and there is nobody with the big picture of what's going on. One of the hallmarks of nursing practice is this holistic big picture, it's the whole family, it's the whole lifespan, it's the whole health-illness continuum, and that's really the basis of our practice. Does that answer your question?

Mr Malkowski: Yes, it does. Thank you.

The Chair: We're going to have to move on. Ms Sullivan, final question.

1440

Mrs Sullivan: This morning in her remarks, the Minister of Health said that she felt that treatment was about procedures and long-term care reform was about relationships. I think most of us on the committee were a little taken aback with that view, in that it seems to us that long-term care is more than simply relationships and in fact is delivering care in an appropriate way to a person who is not well and who does need services that are being provided at the taxpayers' cost or payment, as a result of a need.

Your emphasis on how one gets into the system, ie, the assessment process, it seems to me is quite key. The minister also indicated that she felt that a social worker, by example, could in fact do the assessments just as a person who's involved in providing professional care could.

I wonder if you could expand more on the kinds of tools that should be used, and the appropriateness of treatment needs having a certain priority in determining what care should be provided, whether it's community supports or whether it's health care. I think those are really key issues.

My own view is that long-term care isn't relationships. This isn't a social ball game we're in.

Ms MacMillan: I would be pleased to respond. I think part of the minister's framework for responding there goes back to what we were initially saying, that the main drivers of long-term care reform have been the well elderly and the well disabled. There has been a wellness focus on this, and they have been very effective in making their needs known to the people who have been looking at the long-term reform bill. What we're saying is that there isn't this Rubicon between people who are well and people who are ill; we also have a whole pool of chronically ill people out there.

Probably what we're doing is trying to clarify that it's not as simple as it might seem to start with. This is why, for example, when you're talking about assessments, there would be a need for a nurse to do that assessment,

because nurses are knowledgeable not only about the support and rehabilitation concept of delivery of health care services, which social workers would certainly be involved with, but we're also in that whole issue of health promotion, illness prevention, care and cure, which we're also integral providers of.

There certainly would be treatments involved with some of the clients who would be accessing these services at the MSAs. Again, if we were just to assess the treatment people need, we're going to fragment services. You can teach anybody to do a treatment: In the situation I described, that mother has been taught to look after a ventilator-dependent son, and with nursing support and teaching, she has learned to be quite adept at doing that, but she does not have the knowledge a nurse would have in terms of assessing complications and problems, or even the knowledge a respiratory therapist would have about the actual machinery.

It's just not as easy or as clear as it might seem when you look at it at first blush.

Mrs Sullivan: I suppose some might understand that the diagnosis is as important as the actual delivery.

Ms MacMillan: Yes. The assessment and diagnosis of what services are required here is probably at least equally important to, and maybe even more important than, the delivery of the services.

Mrs Sullivan: I would like to turn to another area we didn't have responses to this morning, although it was put on the table. There have been promises implicitly made that those people who are displaced with hospital restructuring would move into the community-based sector to provide care needs under the new employment structure of the multiservice agency. Have you entered into any discussions with the long-term care division and are you anticipating that any of your members who've been displaced by hospital restructuring will be guaranteed jobs with MSAs? Because you will have other members who are already working for community-based agencies, have you discussed with them the kind of conundrum that will be faced with respect to their own employment?

Ms MacMillan: We have not specifically discussed this with the agencies, but we're certainly discussing this within the profession. In fact, with the reduction in the number of hospital beds there has been no accrued benefit to the communities. Moneys are not being transferred to community services and indeed the jobs that nurses have lost are not being replaced.

The nurses who work in the community setting have a very different focus of practice from that of the nurse who works in acute care. In fact, nurses who work in the community are usually degree-prepared and have had additional preparation in community health and developing programs and that kind of thing, and nurses who work in hospitals are often prepared at the community college level to work with sick people, so you can't easily move one from one area to another.

And I agree with you. We've already got people working in the community. I'm not sure there will be vacancies immediately there. But what we are saying is that we do have currently in this province, we think,

about 5,000 unemployed registered nurses. That's an awful lot of health care expertise that's not being utilized and that the public has very little access to.

It seems to me, as we're talking about who should be providers of care, that it's rather foolish to have spent a lot of money educating professional nurses and now we're talking about educating a whole bunch of non-professional workers to fill in. It does look like it will be less expensive, but we're saying it may actually be more costly in the long run not to have the access by the consumer to professional nursing services in some way.

The Chair: I'm afraid I'm going to have to close it off. I regret, but we have a very full afternoon and we've run beyond our time. On behalf of the committee I thank all of you for coming here this afternoon and for your submission.

ONTARIO MEDICAL ASSOCIATION

The Chair: I call upon the representatives of the Ontario Medical Association. I also welcome you to the committee. If you would be good enough to introduce yourselves, please go ahead with your submission. We have a copy in front of us.

Dr Michael Gordon: Members of the committee, I would like to thank you for the opportunity to speak to you on issues of concern regarding Bill 173. I am Dr Michael Gordon, a geriatrician from Toronto and the chair of the Ontario Medical Association advisory group on long-term care. I would like to introduce you to Dr Barbara Clive, a geriatrician from Peel and a member of the OMA advisory group on long-term care, and Carol Jacobson, the OMA health policy staff support for the advisory group.

The OMA represents more than 20,000 physicians and has as its mission to serve the medical profession and the people of Ontario in the pursuit of good health and excellence in health care. Examining proposed legislation such as this is one of the ways we fulfil our mission.

You have before you the OMA response to Bill 173, An Act respecting Long-Term Care. The document includes an executive summary, which you can quickly review for the OMA's issues of concern. Today we will be highlighting some key issues of concern. Also, for your information we have given you a copy of the OMA response to the government's four Partnerships documents.

The Ontario Medical Association supports the government's objectives of enhancing health care and social services and supports the concept of community-based long-term care and support services for elderly persons, adults with physical disabilities, and persons who require services at home. The OMA is concerned that the legislative framework created by Bill 173 will not be able to effectively meet its stated objectives.

Throughout the planning and development of the long-term care reform initiative, the physician's role within the very important continuum of care has not been addressed except to state what the physician will not be doing. With the changing system and the evolving roles of the individuals within the system, it is important that the consumer knows who is doing what and who is respon-

sible for what. If not, this may have unintended negative consequences on the health status and long-standing relationships which have been developed between the patient, the family and the physician. The physician does have a significant role to play, and the medical community would like very much to be part of the very important process and work with the many providers so that the needs of the patients are fully and adequately met.

The role of the physician, including primary care physicians and the full spectrum of specialists, is multifaceted in ensuring the provision of seamless care to the recipients of long-term care services. I'm going to put a little aside in here: I think we should change "seamless" to "well-tailored." From a family of tailors and seamstresses, I do not know what a seamless garment is, but I certainly know what a well-tailored garment is.

1450

Physicians also act as a clinical resource to service providers. Many individuals who will require and be provided with community-based long-term care will have complex medical needs which are significantly greater than is being acknowledged in the long-term care planning process. It's been noted already by some of the speakers that although many of the individuals may be relatively healthy elderly, we are going to be looking at an increasingly ill group of individuals with many complex medical problems.

An individual's health status changes constantly and in some instances can change quite rapidly. Medical input is necessary to establish an individual's true health care needs. For example, the symptoms of those receiving palliative care who may be on different medications including narcotics must be carefully monitored so that changes in status which require attention can be appropriately identified. The same degree of need may occur in an elder with multiple medical problems, including cognitive impairment. We feel it is important that medical input regarding the patient's physical, psychosocial and cognitive status be an essential component of the MSA's assessment. This will certainly be important so that individuals do not receive services for potentially treatable or even reversible conditions which, if properly identified and dealt with, might eliminate the need for the service or modify it.

The OMA recommends that physicians involved in the various health care sectors be integrated into the decision-making process for the care of the patient moving through the acute and long-term care systems in order to facilitate not only continuity of care but also continuity of communication and support for the patient and their family. It is especially important that local physicians be involved with the DHCs in the local planning of the needs of its communities to ensure the appropriate integration of the role of the physician into the long-term care system.

The legislation addresses in detail the many aspects related to the multiservice agencies which the government considers a fundamental building block of a reformed long-term care system. The dramatic shift of how we provide service and care as a result of the establishment of MSAs will impact the different long-term care health

and social service sectors in the acute care system, long-term care facilities, chronic care hospitals, and special programs such as regional geriatric programs. All will have to interact with the MSA in their area.

The shortcomings of the current system, it is said, are that long-term care and support services are duplicated, fragmented or not available at all. The OMA therefore strongly recommends that where there are multiple MSAs within a catchment area, these MSAs must be closely linked in order to prevent not only duplication of services but to avoid gaps and fragmentation in service delivery.

We understand, for example, that in Metro Toronto the DHC is planning for 15 MSAs with 15 separate boards and an association of Metro MSAs for common administrative, evaluation and communication functions. It is hoped that this does not become a bureaucratic and an administrative nightmare and that clients do not fall between cracks in this new system. For this reason, linkages must include a common database, the ability for individuals to move from one MSA to another within geographic regions, and closer interaction and working relationships of the MSA boards.

In fact, there must be coordination, integration and linkages between all the health and social service sectors, including those sectors involved in the government's initiatives of mental health reform, the chronic care role study, consent, advocacy, substitute decision-making and the changes occurring in the acute care system and restructuring initiatives.

The OMA carefully monitors the health care process in Ontario. We participate in policymaking and consultation wherever and whenever it is appropriate and responsible to do so. From our vantage point, doctors in Ontario are increasingly concerned at what appears to be a fragmented and uncoordinated approach on the part of government in dealing with health care and the reform process. We have reached the point where we have grave concerns about the number and the magnitude of the changes being made to the system without a concomitant understanding of both the short-term and long-term impact on the public and our patients.

We subscribe to health care reform that does what it is supposed to do: enhance the quality of care, improve access and increase efficiencies. Implementing that kind of reform without a fundamental grasp of how all the pieces, both old and new, must fit together is doomed to cause disruption and untoward consequences on those who look to us for care and support.

Dr Clive will continue with the presentation.

Dr Barbara Clive: I would like to address an important area of concern to the OMA: that of consumer consent. This is an issue which, if not dealt with appropriately, may marginalize certain patients.

There are patients who, due to their condition, will respond by saying no when initially asked the direct question, "Do you wish to be assessed for eligibility for services under the MSA?" For example, an elderly widow living alone might readily accept needed services offered by a friendly nurse, but now may not even have that nursing visit until assessed for eligibility.

It is important and necessary to develop a trusting relationship with these individuals. This may take time. Once this relationship has been established, the individual may agree to an assessment or to the receipt of services, even though a direct question using unfamiliar phrases would continue to elicit a negative reply. Also, experience shows that these people will often be reluctant to sign consent forms.

We strongly recommend that the MSA intake and screening system be established with the necessary flexibility to pursue consent in a user-friendly and creative manner with those individuals who, when initially contacted, may refuse assessment or services. It may be that a telephone call will not suffice, and several visits to the individual's home may be necessary.

Culture and language may also be issues that need to be taken into consideration in this matter. The manner in which people are approached varies within different ethnocultural groups. To leave these people out of the system due to their inability to consent according to the law would create definite gaps in the system and would be a disservice to these individuals and their families.

Two of the purposes of this legislation are (1) to ensure a wide range of community services are available to people in their own homes or other community settings, and (2) to recognize the importance of a person's needs and preferences in all aspects of the management and delivery of community services.

We are very concerned that the government has unrealistically raised the expectations of individuals who will be accessing community-based long-term care services. People have been told they can expect a wide range of services that will meet their needs.

We strongly recommend that the issue of needs versus wants be carefully explored when determining the necessity of the community services. This must be adequately reflected in the criteria for the determination of eligibility, assessment, and the service plan which is developed with each client.

For example, a patient, two years following a stroke, may want physiotherapy in the hope that it will return his arm strength to normal. Medically, it is clear that further therapy will not change his arm function. In the past, a physician's referral would have assisted in ensuring that services were provided where most needed. This is no longer required.

This issue may have a significant impact in two areas.

First, it will be critical that sufficient funds are allocated to each community to allow for the delivery of the legislated mandatory services and for those authorized optional services which the DHC has determined are necessary to meet local needs.

Second, the government with this legislation and in its many policy documents is telling the people of Ontario that they will have all sorts of choices and that their preferences will be met. On the other hand, government is telling community service providers that health care dollars are limited, that there is a finite pool of money available.

As Dr Gordon has stated, there will be many individ-

uals with complex medical conditions who will require myriad health and social services to be able to remain in the community. Can the needs of these individuals be met while meeting the expectations of all clients served through this legislation? If so, that is commendable. If not, let's work it out before we build a system that won't provide, if for nothing else than to avoid an unwieldy volume of appeals.

1500

In conclusion, I will reiterate that we want long-term care reform to work but that we want it to work well. Reform for its own sake will certainly fail. The system is at a very delicate point, with no fiscal relief in sight and an aging, increasingly needy population which continues to be promised unlimited access to all the services they want. There is need for improvement, for change, for keeping up with the times. Advocating wellness and supporting wellness programs is admirable and represents a long-overdue shift, but enhancing wellness at the expense of ensuring excellent, accessible and timely community-based care for the sick—and there will be people who will get sick—is not acceptable. We are concerned this may take place under this draft legislation.

Reform must be undertaken in such a way that it will allow the entire system, the entire continuum of care, to be stable and effective during and after the process of reform. Reform must rely on the expertise of the people who are currently making the system work. We urge the committee members to seriously listen to all the presenters you hear from in the coming weeks. We are individuals and organizations who have invested as much time and thought and energy as you in considering how to achieve the best long-term care program for our patients, clients, families and ourselves.

The Chair: Thank you. We'll move to questions.

Mrs Sullivan: Myriad questions come from this presentation, and I know I don't have all the time in the world. Your presentation, following that of the RNAO, which emphasized so much the assessment phase, is an interesting juxtaposition. I think you have taken the RNAO's issues a step further, in talking about the actual diagnostic issues that particularly are evident for the long-term care patient and aren't limited simply to physical problems. There may be psychological and psychiatric problems or mental health issues that have to be addressed as well as the physical issues.

Certainly the points you make with respect to the medical assessments and ongoing monitoring we attempted to put to the minister this morning, to a certain extent, in asking her whether she contemplated medical staff in each MSA as salaried professionals or whatever, and she declined to answer or at least skipped over that. We'll come back to that, because I think it will be interesting to know if that medical component is in fact considered to be a part of the MSAs.

I heartily agree that there are enormously raised expectations, and I wonder if you have been involved in any way in participating in discussions with respect to the criteria for determination of eligibility for long-term care services. Has the OMA been involved in those discussions?

Dr Gordon: Yes, we are involved. We've had some meetings with ministry officials looking at the development of assessment tools, prototypes, systems. We made an initial presentation requesting that we be involved and that was received in a positive manner, and I think this is important.

I wanted to step back to your comments. It was by chance that we followed the previous presentation of the nursing association. There's a false, sort of arbitrary line between assessment and therapeutic intervention. They go back and forth. You're doing them sort of concurrently.

Our concern, in terms of what happens to people—and we're talking about people who have many medical problems. The fact that they can manage in the community with appropriate services is wonderful, but that doesn't mean they don't have real, complex medical—or let's use the word "clinical" and get out of the so-called "medical"—clinical needs that require ongoing assessment, diagnostic, at least labelling or putting it in some kind of framework, and therapeutic interventions which may change in multiple levels.

Which professional is involved with which level is not really the question. It's the fact that you have the professionals who understand what is going on and what the needs may be and what the symptom changes may represent, and this is really quite complex. Anybody who's done clinical care of the elderly—again, I'm using "clinical" rather than "medical" or "nursing," whatever—knows that the changes can be profound and that it takes a great deal of expertise and knowledge in order to deal with them.

On the other part, in terms of the assessment, one of the concerns that we have is that there may be a request for service based on a symptom complex that may in fact be due to a medical condition that, if recognized, is changeable and then the request for services becomes a moot point.

The best example is the person, for example, who has trouble walking. You say, "Well, you have trouble walking; let's send in the walking team." There's the person who fixes up the wall and puts on the grabs only to find that in fact the walking problem is due to an identifiable medical problem for which, if there is treatment, the walking team becomes irrelevant. Parkinson's disease is a very good example. We see a lot of undiagnosed Parkinson's disease that gets referred for a lot of reasons because they don't look like the typical case.

We're concerned that we may lose the importance of the clinical evaluation, and that's really a major concern. Who and how it's done is another issue. As for physicians being involved in the MSA, we didn't create the model of the system.

If the long-term care community-based system is supposed to be in lieu of, instead of, the facility-based system, because that's what we're saying—all facilities have a medical adviser, a physician who's responsible for standards, for the way that the people receive their services—I think if we were designing the system, we would probably include a physician at that level, or clearly in a role to make sure that the medical care

provided within the community achieves standards and expectations, but how it's structured is not for us to organize. We would probably support it.

Mrs Sullivan: I've got a wee one. Many people, although not all, who are seeking long-term care, will have an established relationship with a family physician. How do you see that family physician tying into the MSA as proposed?

Dr Clive: Perhaps I'll answer that, practising as a community physician in Mississauga.

We would like to see the family physician be part of an integral communication loop that involves the patients, and the goal is to make sure they're getting the best care available; continuity of care. The present design of the system, which tends to exclude the physician even right at the very beginning, at the initial referral process, doesn't fit into that model. As you mentioned, these patients often have a very long-term, ongoing relationship with their doctor, and we would certainly like to encourage, in the way the system is designed, some mechanism for communication with the physician.

At the present time, whenever someone is placed on the home care program, they have an attending physician identified. I think this is key when we are dealing with complex cases in the community whose medical needs may change on a day-to-day basis. The staff caring for those persons and assisting them in their homes need to have someone they can call who knows these persons well and who can assist with sorting out the various medical or non-medical concerns that may come up. So we see that it is key to have the family physician as an integral part of the communications circle around that client.

Mr Jim Wilson: Thank you for your presentation. Just around this very point, I wonder if you can suggest something a little more specific, perhaps, on how we put a remedy into this legislation.

For example, a couple of weeks ago, a lady in my riding called me at 9:30 on a Sunday morning—sorry, it was actually her son who called me. The lady was in pretty bad shape and the son couldn't get really enough home care or community-based services and he could no longer really look after her in her home—and I'm making a very short story out of this. He said, "Jim, what do I do?" I said, "Well, take her over to emergency and just tell them you cannot look after her at home any more," because that's the quick solution to get into the system now.

Eventually, throughout the day the family physician and the placement coordinator—or she used to be the placement coordinator; they've basically fired her now and she's just doing it on a volunteer basis—talked her into, "You're going to have to go to the local home for the aged." It all worked out okay after a couple of days in the hospital.

But there was the family, who couldn't confront the decision even though they'd known for a couple of months that perhaps she should be going into a long-term care facility, that this was going to come. There was the physician, who was her friend, finally breaking the news

to her and saying, "Your son just can't look after you at home any more."

1510

And you're right. How does the physician work into this? Because you point out in section 22 that any approved agency can't do an assessment and there's no automatic link to the physician. You raise a very good point. I mean, in my scenario what would happen? The act went through as is. I can't believe this would happen, but the physician would basically have no say in this and somebody would phone the MSA and the MSA would go over to the emergency room. But the lady's obstinate and doesn't want to go to a nursing home. She doesn't want to be assessed because she knows, "Well, that means I've got to go to a nursing home." Do you know what I mean? You must deal with it all the time.

Dr Clive: I know what you mean; I deal with it all the time.

Mr Jim Wilson: I only deal with it the odd Sunday.

Dr Clive: I want to tell you it's a miracle that she found a place to stay in a few days. Where is it she is?

Mr Jackson: Well, this is on TV.

Mr Jim Wilson: Phone your MPP.

Dr Clive: Right, phone your MPP. You'll get a nursing home bed in no time.

Mr Jim Wilson: They'll bring in an MSA and we'll be out of the picture too.

Dr Clive: I think there are several issues that this case demonstrates. Number 1 is the assessment of competency of the individual and her ability or right to refuse treatment or placement, and certainly that issue—the family physician plays a key role in helping to assess the competency of that individual. Perhaps she was not competent and yet refused and no one was asked to make that assessment and so the family kept following her word when they were unable to meet her needs and placed her at risk, and the whole family at risk probably from an emotional sense.

The second is, what is it that precipitated whatever happened on Sunday morning? My experience is, when I've been following patients who are in the community who perhaps are even on a waiting list, a long waiting list, for placement, they are doing fine until a medical event occurs, something that changes their medical status. Again, there is a place for the doctor or an experienced nurse to come in and identify the change of status to the physician and say: "There's a problem here. Something has changed. What is it? What can we do?"

Sometimes going to the emergency department—I shouldn't say this—may be the right thing to do because at least there you can get some tests done and you can find out if there is a new, reversible problem. If there is, and that's something that can be treated, perhaps that person can be stabilized in the community again to await placement. Perhaps that event has been catastrophic, such as a stroke, a new, irreversible medical problem that will now mean they cannot be managed at home.

The other time that things happen is, perhaps the crisis was not in the patient or client but in the family, the

acute illness of a care giver. Presently, in many emergency departments, we have quick response teams and these sorts of emergencies come up where we can facilitate placement or institute community services to support that person at home in the absence of the care giver. But so often in that situation there is a key role for the doctor because there are several problems that could have occurred and the physician is important in that.

Mr Jim Wilson: Well, there are many areas in rural Ontario where we don't have quick response teams either or many of the other things that are talked about at these committee hearings.

Dr Clive: Yes, and a lot of the things that are in this legislation, I think, create problems because of lack of service. Then we have to say what is appropriate in terms of waiting lists for various services that are not available in rural communities. I live in Halton and I service north of Peel where we don't have a lot of the services that are supposed to be in these beautiful new structures called the MSAs.

Mr O'Connor: Actually, following right along with the quick response teams, how do we then—in the case of an assessment here, where there is a quick response team available, you can then make some of those assessments, evaluations, and get the appropriate care provided. How do you suggest we inform the physicians or partner, or whatever, to get the physicians to know that there are other services available that they may not know about?

A common problem that would be found throughout the province is that the referral patterns of physicians don't necessarily match the referral patterns of some of the medical treatment facilities. We all look back at our own home ridings; it makes it a little bit easier. But if somebody from Orillia or somebody goes to the hospital in Orillia from Beaverton and they get sent back home, they're sent back down into Durham region again. How do they know where to look for services? Sometimes from Durham they get sent over to York County Hospital, where we do have some services, you know, quick responsewise. Make sure that the physicians know that there are services that could be available. They don't always know what's available. I think this is where we can actually help by going through this process. An MSA is going to actually help the doctor make a better referral.

Dr Gordon: I think with some of the discussions we've had with the ministry we've tried to emphasize the importance of the link, loop, communication system between the primary care physicians, the responsible physicians, and whoever the MSA participants are. Certainly, whether the system—through education or however you make sure people know where they refer—will enhance services, I don't think any of us disagree with the contention that having an easily identifiable organization or grouping to deal with services is good. I think we all have no question with that.

The other question is, I don't think any of us want to be gatekeepers any more. That's an issue that we've long been happy to relegate to anybody else. But we want to make sure that in the loop of care we are active participants, because many parts of that loop—if you want to call it a chain, there are many links in it. Without our

input, we may end up doing the wrong things for people who really have a lot of complex medical problems; we know that there are those who don't and have very simple needs. Whether it's shopping or something, cleaning the driveway in the winter because they have a simple physical disability, that's an easy group to look after.

But we are already seeing people discharged early from hospital who are not having access to long-term care facilities who 10 years ago there wouldn't have been a question that they would require a long-term care facility. We're trying to patch together a way of keeping them in the community. For many people that's fine, but their health care problems don't disappear, and if they're not managed well, then we will end up not providing appropriate services and when they get to the long-term care facility it will be in much worse shape than they were.

Mr O'Connor: I think the problem we've had is it has been patched together, over a long period of time, and what we're now trying to look at is pulling things together and making them more comprehensive.

Dr Clive: I agree with the concept of the one-stop shopping. So, for the physician, if we can get that phone number into the physician's head, whether it's 451-HELP or something like that, then that will be wonderful. At the moment, if I have somebody in my office who has several problems and needs services, I have to phone five different numbers. So the idea of consolidating this I think is wonderful.

I do sit on our DHC long-term care advisory committee trying to develop an MSA, and I am worried that once that phone call is made there are going to be 10 days of paperwork before that client ever gets services. Right now I know who exactly to call to get a nurse in there this afternoon. I may then have to call somebody else to get a homemaker and somebody else to get a physiotherapist, but that's another story. But when I hear that the initial draft of the assessment form or referral form is 26 pages long, I think, "Is this really going to improve service?"

The Chair: Thank you. I know there are many more questions. We could pursue this for some time, but I regret that I must call it to a close as we still have many other presenters this afternoon. But thank you again for coming.

Dr Gordon: Thank you for having us.

Mrs Sullivan: Mr Chair, I note that in the Ontario Medical Association brief there are some quite specific recommendations that are detailed in relationship to the bill. I wonder if we will have an opportunity to look at these at some point. Some of the things that were included, by example, are evaluative mechanisms for paraprofessionals and other instances, such as the banking and finance issue that I raised this morning. I think that, because they are more specific and less generic than the discussion that we've had, it would be worthwhile to look at these quite particularly.

1520

The Chair: Thank you.

YORK REGION HOME CARE PROGRAM

The Chair: Welcome to the committee. If you'd be good enough just to introduce yourselves for those who live outside of York region and then please go ahead.

Ms Carol Dockrell: Thank you, Mr Beer. It's comforting to see a couple of familiar faces from York region on this committee. My name is Carol Dockrell. I'm the director of the York Region Home Care Program, and with me is Brenda Andrachuk, a program manager, to assist with any of the questions. I'll be doing the presentation.

I'm representing 127 staff and contracted rehabilitation service workers of the program today. I would like to stress that I'm not speaking for the administering agency, the York region municipal government. They will be doing a presentation later on in the hearings, so I did want to make that point very clear.

The staff that I'm representing include 46 case managers, sometimes known as coordinators, depending on the program; 28 clerical support staff; 44 rehabilitation therapy staff and contracted workers; and nine administrative staff. I would like to say—and I deviate the odd time from my written presentation here—that I feel quite comfortable to speak for these 127 people because we did quite a lengthy in-house process over April and May within our program to have a task force representing all of these groups go into the detail of our paper and to distribute it to everyone. So everyone had an opportunity to have their say, give their feedback, and I believe this truly does represent—it's not simply myself or my colleague.

As I begin my presentation, I would like to underscore a significant point. Although we are indeed workers in the system, health and community services, we also believe strongly that we are consumers. Many of us are dealing with or have dealt with aging parents, terminally ill family members and friends, critically ill children, and personal health and social issues. We are, of course, also taxpayers, and we believe we have the experience and the knowledge to assess the cost implications of an ideal as well as a realistic approach.

I have personally held my position for almost 17 years. I think I am one of the more senior or long-term people. I've watched a lot of changes in the system. I truly do believe that my staff colleagues, both here in York region—in York region, rather; I'm not in York region—as well as our local partner agencies are responding to this proposed future wearing not only our worker hats, but indeed our consumer and taxpayer hats.

In the package I'm leaving with you, you will find three documents, and I'm really only very briefly commenting on some of the issues in there.

The first one is the staff recommendations for a multiservice agency in York region. It's very specific to our thinking in relation to where we work and live.

The second is entitled Factors to Consider in the Planning of an MSA: specifically, acute short-term care; secondly, age-related issues; and thirdly, palliative care. I am going to speak more to those in a moment.

Finally, we have the preliminary results of a survey

that we recently conducted in April and May of clients receiving services at our program, and I will speak to that, but there's more detail in the documents for your reference. I would appreciate your attention to this detail. Time does not allow me to extensively review it, but it is very relevant, I believe, to the reform of the system, and although it's specific to York region, I think there's a lot of applicability across the province.

So in the time available to me now, I will highlight certain key points which I did review with my senior staff last week to assure their relevance today.

"Acute Short-Term Care" is my first point. These aren't necessarily in order of priority, but this is one that I'm constantly raising in my circles and I wish to stress it today. Throughout the lengthy process leading up to this bill, including all of the actions of the previous government, I believe there has been a glaring lack of acknowledgement of the impact of acute care. In our home care program in York region, in the fiscal year just ended in March, 65% of those individuals we served in that year were served through the acute care program and the 35% remaining were served through our chronic and our integrated homemaker programs. I did not factor in the school program for this particular analysis. I would like to point out as well that in our particular program we serve all of the palliative care clients through our chronic program simply because it saves transferring and a lot of administrative work. I certainly believe that all or most palliative care clients could easily be defined as acute, and that's an interesting issue that often raises the distinction between acute and chronic.

We believe the administrative implications for acute care in planning for a multiservice agency funded within a limited global budget are enormous. I have made only three points here; if I had time, I could go on.

In our program, approximately 75% of all of our acute care admissions to the program are direct discharges from hospitals, and I expect that is relatively typical provincially. In most current geographical home care locations there are several local hospitals, and many home care programs deal with hospitals outside their boundaries, a significant factor in large urban areas, and most particularly within the greater Toronto area. I have to say York region—I'm sure Peel and Durham would say the same if they were here—are strongly impacted by the 30, give or take, Metro hospitals.

In today's health care environment of shortened length of hospital stay—and we've seen a dramatic change in the last few years—quick response initiatives—I heard you speaking about that earlier—to serve clients presenting in the emergency departments, communication needs to be efficient, effective and rapid. The integration of acute care community services within a multiservice agency has significant administrative implications.

My second point is somewhat tying into that. In a competing fiscal environment—which, from my read of the situation, it appears it will be—how will the board and the administration determine priorities to respond to hospital pressures as well as social service pressures?

Thirdly, the more MSAs established throughout the province—and I've heard numbers ranging from 100 to

150 as potential—each with their local “flexibility,” the more potential there is for communication problems. Most of the current 38 home care programs will attest to the challenge we face today in interprogram and inter-agency referral and communication.

Ontario has a very mobile population. As stated earlier, they often receive their medical care in a hospital outside of the area where they actually live. Imagine the challenges for physicians—and I was quite interested listening to the part of the previous presentation to hear that—and hospital staff in determining the process to contact and to interpret the flexible approach of one of 100 to 150 MSAs.

My next point is just some brief comments around the “Union and Non-Union Staff Issues” that will inevitably result from this proposed direction. In our opinion, the magnitude of the resulting issues emerging from establishing the MSA model proposed in the bill are staggering. We understand there are seven different unions affected within home care programs in this province, and two of those are currently within the structure of York region. The integration of agency staff from other non-union areas into a union environment has enormous implications.

We seriously question the cost-benefit of merging current administrative structures of home care programs and contracted agency services. We have never seen any evidence to analyse the potential costs of both transitional costs and the new system weighed against the benefits of the future outcomes. Our experience suggests to us that it would not be cost-effective to change in the radical way that is being proposed.

That leads nicely into the next point, which I’ve titled “Corporate Merger Versus Contracted Service Delivery.” We believe that proposed direct service delivery by a staff of 80% minimum, which is, I understand, the intent of the bill, is not an appropriate direction. We support a contracted service delivery approach with quality and cost-effectiveness as the key criteria.

As noted in my last point, the costs and implications of such a merger are quite enormous. We believe that the principles of reform can be addressed without such a merger. We’d ask that you please refer to our client survey report, when time permits, contained in the package. For clients who’ve been able to access the system—I’m only speaking, I admit it, for the home care part of the system—there is a very high degree of satisfaction in our region; 53% of 244 people who responded to our survey—we sent out 500, so it was almost a 50% response—rated the program as excellent. Another 27% said very good and no respondents rated it as poor.

In our minds, this raises serious doubts about the need for the drastic change proposed to the system. In fact, we are concerned about the risk of creating a less effective system in the end.

During this lengthy process of consultation and proposed reform, it is “business as usual” for home care programs and the agencies that are potentially affected by the proposed merger. Certainly in York region it is not business as usual, in my opinion, since we are experienc-

ing dramatic case load growth as a result of hospital changes and other factors and much greater complexity in the kinds of services, care and support we are providing.

The expectations to participate in numerous, often repetitive meetings are placing undue burdens on staff already stressed by demands. An often-quoted comment is that the merger will save significant administrative costs. I have seen no analysis to support this supposition. As a long-term administrator in the current system of contracting services, I seriously question the validity of this.

1530

The next point we’d like to comment on is the not-for-profit policy. We do not support this policy. We believe that consumers and the system are best served by a mixed approach of not-for-profit and for-profit agencies. Currently, all agencies receive the same fee regardless of their administrative character, and our experience does not suggest that quality is greater from the not-for-profit sector. We have difficulty, therefore, understanding the rationale. Furthermore, we believe that costs would be greater to the taxpayer, ourselves included, with the 80% staff approach.

We fully support the principles of improved service, better communication and easier access for consumers, but we do believe these could be accomplished equally well, if not better, through a contracted services system.

The next point is related to services to children. We are concerned with the emphasis on seniors throughout the evolution of the reform process. While we fully support and we acknowledge the need for unique service delivery to this population, we believe that the paediatric population has unique needs as well. As Brenda and I were chatting in the car, it’s our observation that the public speaking for the paediatric population isn’t nearly as well organized and obviously not perhaps as strong in numbers, so we’re concerned that this group may not be heard and our fear is that their needs will not be addressed adequately because of the long-standing emphasis on other groups.

Palliative care: We believe that palliative care to terminally ill persons at home, when desired by the client and family care givers, is one of the most effective and supportive roles the program currently provides, along with many other partner agencies in the community. It is a very cost-effective alternative to hospitalization, which would be required in a substantial number of situations. More importantly, however, it provides a special and unique quality of life to those undergoing the experience, clients and care givers alike, and the rewards in terms of the surviving care givers and family are immeasurable.

However, the growing nature and increasing medical complexity, such as intravenous therapy at home, are significantly impacting on costs for nursing, homemaker support, supplies and other costs in the community setting. Planning for the future must recognize this shift from hospital to home and will have to rationalize the costs. If budgets are capped, a serious dilemma for the administering board and administration will undoubtedly be faced.

If I could speak now just briefly to age-related issues, our point is simply not to forget that the proposed MSA model will be serving all ages. There is a widespread assumption that the majority of clients are seniors, and this is not accurate. It's certainly not in York region; it may well be more so in other areas. We again would ask you to refer to our attached reports for the details. Often, clients in the under-age-65 adult years—many, I think, here would fall in that category—are high consumers of service, particularly in palliative care situations and other situations of long-term care, since there is often a working spouse or partner.

Volunteer issues: We know that this is a controversial and often-stated objection to the proposed reform. Our home care program does not have direct experience recruiting and working with volunteers, so we do not feel qualified to provide a firm opinion. However, I did want to say we lean in the direction of having concern about the ability to attract, retain and recognize volunteers in a large bureaucratic organization.

We have watched the highly successful use of volunteers in our home support for seniors agency in York region, known as CHATS, Community Home Assistance to Seniors, and we are sceptical that the dedication and spirit would be comparable. We are referring more to volunteer client services in the home setting in the community, as opposed to volunteer board member services, which we think would likely be more easily achieved in a community-based board.

Governance: I wasn't going to say anything. As I said earlier, our region will be speaking. I believe it's appropriate for us to simply say we do a staff-endorsed consumer participation in any governance model. We are currently employees of the regional government in York region, and as such you can likely appreciate our difficulty in being any more specific about a governance model.

We appreciate the opportunity to have our views heard and considered. In summary, while we acknowledge the need for improvement to the system, particularly in terms of consumer access and effectiveness of communication, we believe that radical restructuring is not necessary. A more modest approach to improving and building on current strengths is our preferred approach.

I thank you for your time and I certainly am pleased to answer any questions.

The Chair: Thank you. We thank you as well for the attachments that you brought with your brief and we will look at those closely. We'll begin questioning with Mr O'Connor.

Mr O'Connor: Thank you. I appreciate the opportunity to welcome you down to Queen's Park on behalf of Mr Beer and myself.

Ms Dockrell: Both of us long-time residents of Ontario have never been here. This is an unexpected bonus.

Mr O'Connor: We're not that hard to come before, actually, and we've had representatives from York region come before us and we always treat them quite nicely, as we do anyone else. I hope we don't scare anyone who

may come forward. In listening to your presentation, I want to kind of point out that we see the home care program that's there now, which has, I think it was, a \$2-million increase year over year just this past year and the integrated homemaker program that's under way and what not, we see all of this as coming together to be part of what will evolve as the MSAs.

Maybe you could help me and some of the committee members. I think we're going down a direction that'll help us progress in providing services into the community a little bit better than has been in the past, and I think if we took a look back at the historical importance of a lot of the services that are out there today, they evolved over a long period of time, and it was because of a need within the community.

You'd pointed to some problems that you see in the involvement of an MSA locally, and I just wondered how you see this as being a problem. There's going to be a core basket of services that'll need to be provided. Would not the services you provide still be part of that? Do you see that being eliminated somehow?

Ms Dockrell: No.

Mr O'Connor: What seems to be the problem there?

Ms Dockrell: Primarily, the potential administrative structure we see as being no proven or demonstrated benefit to changing the current structure, which is essentially my point around contracted versus merger. Certainly, having dealt with other large organizations—and I believe this again confirms the point being made previously—in attempting in reality to weave your way through a large bureaucratic structure causes us some concern. I guess our point is, for our clients currently, having asked them, "Are you happy with what you're receiving?" and they are, we're asked: "Then why are we changing? What is the benefit to change?"

Mr O'Connor: I guess the difficulty here is that there's a limit in some of the services you provide. I know that with all the agencies that came together and put in a request to the ministry for palliative care dollars—and with that we saw things like the Georgina Hospice come about, which is going to provide services to people at home in a palliative care setting that is something different than what you offer now.

To me, if a client, a consumer who is going to need some services now has the ability to go and make one phone call that's going to give them access to all the services that CHATS provides—in fact, the Georgina Hospice and CHATS have worked together in some of that—all those types of services actually just with one phone call, I think that would be better for servicing not only the needs you fulfil now but some of the needs you don't fulfil; then, if the service you are providing should be accessed, maybe a different way of accessing it.

Ms Dockrell: I didn't comment in my presentation, but we fully support improving the access particularly for those who aren't in the system. We believe once they're in the system, as far as the home care program part of the system, that they're brought into the system quite efficiently and effectively. We fully support improving the access for the consumer who doesn't know how to get

into the system. In fact, in York region we're currently proposing and have had meetings over the last three months with our partnership agencies to do a demonstration trial project on a 1-800 access number in York region. We believe, however, that can be accomplished without the changes proposed in the bill, within the strengths of the current system, and we intend to hopefully demonstrate that before the end of March.

1540

Mr O'Connor: Have you made a presentation to the DHC in York region?

The Chair: We've going to have to move on, Mr O'Connor. I'm sorry. We're tight this afternoon for time.

Mrs Sullivan: My comments are with respect to proposals that York home care has made with respect to what's almost a managed competition model, whereby the MSA would be the point of access, the one number that people would call, whether they be the professional who's referring a patient or a person for services or whether it's the individuals themselves who are calling for information. I think your concept is that the MSA would then contract for services on the basis of quality, cost, the innovative approach and the evaluation of the services that are provided.

One of the things that is of major concern—and I hear Mr O'Connor speaking about the Georgina Hospice—is that most community-based agencies which are now providing services provide more services than those which are funded by the government. Once those services are reduced by 80%, ie, once those services will now be provided by one new government bureaucracy, the services that are left that those agencies provide will in fact become too expensive in administrative terms and other means and therefore those services will be lost.

I'm wondering if you could describe what you see from the home care perspective of the effect of the loss of services above and beyond those which are government services in the York community and if you want to comment more on the managed competition which would provide the triage services initially and then referral out.

Ms Dockrell: It's rather difficult to comment in the sense that it's hard to know just what potentially stands to be lost. I understand your point and I share your concern about that, but I have difficulty conceptualizing in my mind or making clear in my mind just what stands to be lost, presumably some of the services currently, as you say, not funded.

I know from personal experience, having worked as a visiting nurse many years earlier in my career, there's no question that nurses, I believe, who currently work within the visiting nurse agency structures have an incredible dedication and spirit. I personally think that kind of thing's going to be somewhat lost.

I personally, as a nurse with my background, have concern about that sort of—it'll be a 9-to-5 sort of approach, very much different than the spirit that currently exists within these agencies that have a long-standing tradition and history and somehow instinctively instill that kind of attitude within the staff who work there.

As far as the other specifics are concerned, though I do

have some difficulty commenting on them, I share your concern.

Mrs Sullivan: Could you talk about the managed competition proposal then?

Ms Dockrell: Do you want to comment, Brenda?

Ms Brenda Andrachuk: I just wanted to say that part of our point was that all of these services are already available. All of the services that you're proposing that will go into the basket are available: as Larry pointed out, the Georgina Hospice, and within the home care program we can access that right now. It seems like we're trying to rebuild a system that's already in effect. We just have to tidy up some things and get some things put in place that make it more accessible for the everyday consumer. Because that's what we're trying to do, make it a better system for consumers who don't understand the system but know they need some kind of help.

Ms Dockrell: I'd like to just comment on that as well. I don't have any data, but in preparing to implement a 1-800 number in York region—and we did use one when we implemented our integrated homemaker program, so we've had some experience in getting the word out—we actually had a very good response with very limited—we just used cheap little flyers to get the word out. So we're going to continue on with that process.

But in preparing for this, we've been doing a survey of individuals currently calling into home care programs, VON, homemaker agencies, placement coordination services etc, and it's interesting. I wish I had the results, but I saw the first about a week and a half ago.

One of the questions we were asking these consumers was, "How many calls have you made before you—" because once they got to one of these agencies they're going to be into the system right away because of the network. We're being surprised—I think there's perhaps an illusion, and maybe it's unique to York region so I wouldn't want to say this applies provincially—that the consumer isn't making that many calls in actual fact.

I would personally love to have seen a more scientific study done on that with consumers as opposed to perhaps the emotional feeling that people bring to a consultation, which I know reflected that consumers were expressing a great deal of concern about that. But that may not be the findings that we're seeing, which is interesting.

You wanted me to comment on managed competition, I guess, back to the original point. I think I was reflecting the strong feelings of the staff and rehab workers in our program that we have had very positive experience in all the years we've worked within what we believe is already a managed competition system. We see many, many pros, but we see a great deal of cons in moving away from that system into a system where all workers are on staff.

We believe there'll be some disincentives to productivity; some disincentives to competitiveness, which will lead potentially to increased costs; many, many issues around unions, union implications for a large organization, and just the sheer time involved for all the communication to be accomplished in that process of working with unions and the collective agreements.

Mr Jim Wilson: I just want to, on behalf of our

caucus, thank you. Your presentation gets five stars with respect to every section. It reflects very much what we've been saying for at least the last four or five years with respect to some of the reform that is going on in our health care system and in long-term care. I think you've been very, very honest.

When we started into this process it was going to be fairly simple: one-stop shopping, a 1-800 line. There were going to be some provincial standards. It wasn't going to be this complicated malaise that we have now in Bill 173, and I think you're right, there is another agenda at play here and it has a lot to do with unionization and ties into the labour laws that were passed last year. It's get everybody under one umbrella and do what they can while they're still in office, and you're the second one so far today—the Ontario Hospital Association hinted at it in its press conference, in reading between the lines, and you've indicated it fairly clearly on page 4.

You later didn't want to comment on governance, but this is appointed regional government in long-term care; that is essentially the way I look at it in terms of the amalgamation. A lot of these agencies that come to us and ask, "What's going to happen to us with the MSA?" "Well, you won't be around in a few years." It's that simple.

Something has to give, or the government truly is building a big bureaucracy on top of a lot of existing administrative structures now. They say they're not but they won't tell you exactly what the new picture looks like. So something's got to give. Boards have got to go, administrators have got to go, staffs have got to go, and everybody's coming under one roof. I think that's pretty clear to me over the past few months and will become, I think, clearer to everyone throughout these hearings.

I do want to ask you one thing, though, because it's something that my party's been harping about for quite a long time, and that is your comments about the not-for-profit sector. You are in the not-for-profit sector yourself, being in the municipal sector, yet you're one of the few not-for-profit groups who come forward and say that this arbitrary 80-20 mix just doesn't seem to make much sense and that you're currently contracting out services, I assume, based on what you say here, "quality and cost-effectiveness."

Can you give us any feel, because you only get a minute, as to what the new policy might do in human terms? Will you have less flexibility, or is it a red herring, as the government always tells us?

1550

Ms Dockrell: I believe there'll be less flexibility. We've observed over the years tremendous flexible and rapid response from both the not-for-profit contracted service agencies—and I'm really speaking most specifically here probably about the nursing and the homemaker agencies, which are the ones where we require quite rapid response very quickly, and becoming more so all the time. Our experiences have been very, very positive with both sectors. I've just lost my train of thought. I do believe there will be less productivity in the proposed system.

Another area that concerns me is the whole area of standards. Organizations such as Red Cross, such as Saint Elizabeth Visiting Nurses, such as the Victorian Order of Nurses, have a long, long, long history of developing, refining and adapting standards, very often in collaboration with home care programs once they entered into a purchase-of-service relationship, and I think those are excellent standards. I don't know what happens to them if these agencies no longer play a significant role.

I know they can still play a potential of a 20% role, but presumably multiservice agencies will have to reinvent the wheel in terms of these standards, and you're talking quite complex care standards. Particularly as we've moved into more high-tech-type treatments and approaches in the community, I believe that would be an enormous, time-consuming activity that each MSA would have to undertake to provide the professional and supportive services of nursing, homemaking and rehabilitation services as well. No one has any idea of the time involved and the cost to do that.

Mr Jim Wilson: It strikes me, if I may just say, for instance, take Simcoe county, next to you. I think we're about 97% non-profit agencies delivering a variety of services, yet they're accountable to the public through their boards, and their argument to me all the time is, you know, who loses in all this is the consumer.

Right now you can go into the Red Cross and absolutely scream at them and you can go to their volunteer board members that you meet at the IGA store, and things get fixed pretty quickly if you make a complaint; and there are very few complaints, I might add. But now everyone's going to work for the government. Everyone's going to work for the MSA.

In all the reading you've done, who is the MSA accountable to?

Ms Dockrell: That is an area of concern. Again, I know this will be an area our administering agency will speak to. They share that concern of accountability.

Mr Jim Wilson: But they're appointed by cabinet.

Ms Dockrell: Presumably the board will be appointed members, as opposed to publicly and democratically elected. So there is a concern around that very issue.

The Chair: Thank you both very much for coming today. I'm sorry. I know there are more questions that could be asked, but we do have a full afternoon. So again, our thanks.

ASSOCIATION OF TREATMENT CENTRES OF ONTARIO

The Chair: I then call upon the representatives from the Association of Treatment Centres of Ontario. Welcome to the committee. If you would be good enough to introduce yourselves, we have a copy of your presentation. Please go ahead.

Ms Joanne Renahan: We are pleased to have the opportunity to make this presentation to the standing committee on social development regarding Bill 173, An Act respecting Long-Term Care.

My name is Joanne Renahan. I'm the executive director of Lansdowne Children's Centre in Brantford, but I'm here as chairman of the Association of Treatment

Centres of Ontario's long-term care committee. With me is Ross Lawless, chairman of the association's board of directors, and Diana Thomson, member of the association's long-term care committee.

The Association of Treatment Centres of Ontario represents the collective voice of 20 children's treatment centres. The centres are community-based agencies funded by a number of government ministries as well as by municipalities and private sources. They are multi-service, providing a broad range of programs for children and their families. A detailed listing of the services is provided in appendix A.

The association is committed to providing leadership on a regional and provincial basis in planning, developing and providing services to enhance the quality of life for children and young adults with disabilities.

With that in mind, the association has been monitoring and seeking active participation in the proposed redirection in long-term care and support services in Ontario since the beginning of public consultations in 1991. As a representative of children's services, many questioned why we were so concerned about an adult system. However, we knew that the impact would be significant due to the school health support services program currently being administered under the home care programs. To clarify, let me briefly provide some background.

In 1984, in response to Bill 82, regulation 452, section 44(a) under the Health Insurance Act established the mandate under which home care programs would provide services in the school setting to students enrolled in special education programs. This is now commonly known as the school health support services program. This action was taken without any consultation with our association or membership, in spite of the fact that many of our members had been providing the major aspect of this service for decades. In fact the majority of our members continue to actually deliver this service by contract with the home care programs.

Our concerns about compromise to our service model, service fragmentation and duplication of legislated mandate were thoroughly reviewed with various ministry staff. There was an independent substantiation of these concerns via a study conducted by Price Waterhouse in 1989. The relevant text is attached as appendix B, but basically the conclusion was reached that school health support should be transferred to children's treatment centres.

Why no action? The main problem was there was no mechanism available for flowing school health support funding directly to treatment centres without a legislative change. The association reluctantly accepted the situation because of ministry assurances that we would see a resolution when the long-term care legislation was introduced. You can understand our surprise when we read that the intent of the long-term care legislation is to entrench the status quo rather than implement the Price Waterhouse recommendation. That is why, for the first time in the association's history, we feel compelled to appear in front of a legislative committee to advocate for children with special needs.

As is often the case with human service issues, a detailed outline of every implication can be overwhelming, so for the sake of brevity we've given priority to three concerns: status of children, fragmentation of the service system and discrimination.

With regard to the status of children, our position is simply that children are not and should never be viewed as little adults. As a society we acknowledge this in many ways, but every now and then, for whatever reason, perhaps due to an honest belief that in a particular case they are not that different, their unique service needs are not acknowledged.

We suggest that the systems established for their education, child care and acute health care have been established because they are different. There are few, if any, who would question the need for paediatricians, hospital wards, head start or recreational programs etc that specialize in servicing children's needs. Trying to make a child fit into an adult long-term care agency is analogous to asking him or her to make do with an adult wheelchair.

As an association, we applaud the work done by the Premier's Health Council, outlined in its recent report Yours, Mine and Ours, which speaks to the importance of planning for children on the basis of developmental transition needs. As service providers, our members have long promoted and practised the developmental service model to address the constantly changing needs of children. This model requires a team approach by people who understand children, are specially trained in paediatric services and have the opportunity to develop and reinforce their skills in a paediatric environment. Our concern is that this legislation is going to entrench some services for children in an adult agency. It is imperative that this not take place. Decisions about children's services should be made on the basis of their needs and not on the basis of expedience.

Our next major concern is with regard to the fragmentation of the children's service system. If I may be allowed to use an analogy, it appears to us that in recognition that the family home needs some renovation, we are tearing the house down and building two town houses. This fragmentation has potential implications both on established services and on the current planning and reform that is occurring in the children's service system.

1600

With regard to established children's services, the potential growth of a parallel system within the multi-service agency is apparent. A specific example is a recent consultation paper on the school health support services program initiated by the Ministry of Health's in-home services branch.

While this paper notes that resources are scarce, it offers for consideration the expansion into a number of new areas for this program, such as summer services, transfer of services into the home, transportation, equipment provision, social work and behavioural consultation. We would suggest this need to consider the expansion of the school health support program recognizes that the needs of the child and family go beyond the school. It does not, however, recognize that these services are

already in place or under development in the children's service system.

We cannot support the notion that the resolution of current service fragmentation is best addressed by establishing a parallel system when the opportunity for developing a fully flexible, coordinated service system for children already exists. Not to take advantage of this opportunity is particularly alarming when research by the Ministry of Health-funded neurodevelopmental clinical research unit reveals that organized programs of service such as are provided at children's treatment centres do a better job, according to parents, than do scattered pieces of service received across the community. We therefore earnestly request that plans to establish a parallel system be abandoned.

Another direct service implication is in relation to a number of established children's programs presently funded by the Ministry of Community and Social Services. Specific examples are respite care and the highly successful special services at home program. In discussion with our children's service system partners, we find we are not alone in identifying that the mandates of both these programs fit components of the MSA's mandated services. It is our concern that this type of duplication has not been considered in the drafting of the long-term care legislation.

We grant that parallel systems are not intentionally planned, but they do happen when, as we believe is happening here, a small service component of one system is transferred to another or a service reform occurs in isolation of other parts of the system. It is critical that the sector planning and reform presently occurring in the children's service system be recognized.

Key reviews and reforms are occurring in the following areas of children's services: child care, special services at home, education, children's services policy framework and speech and language services for children. Our members are striving to participate actively in all these initiatives. However, what is required is a provincial commitment to support the coordination of these many planning initiatives. This commitment is essential for the development of a truly integrated customer-focused children's service system. Our fear is that the inclusion of any children's services in the proposed MSA is going to heighten service fragmentation and isolation.

Our third concern is that this reform not only supports the discrimination the school health support services program introduced into the system, but it's going to reinforce an old discrimination that the association thought it had conquered.

The discrimination introduced by the school health support services program is age discrimination. Unlike their school-age counterparts, preschoolers with special needs have limited access to therapy options and are denied access to nursing and dietetic services in child care settings. It has been suggested by some that in child care the responsibility rests with the Ministry of Community and Social Services. If this is so, why has it been clarified that this responsibility does not rest with the Ministry of Education for school-age children?

The association's position is that all of these services

are unquestionably health services and, as such, are the responsibility of the Ministry of Health. It would be considered ridiculous to suggest that the Ministry of Community and Social Services should pay for preschoolers to see their doctor.

It is our position that health services should be equally accessible to all. We would further suggest that this particular discrimination is of even greater concern, given the government's commitment to prevention and early intervention in childhood. This inequity must be addressed as part of a children's service system reform.

The second area of discrimination is with regard to the exclusion of people with developmental disabilities from this reform. It is acknowledged that their needs are to be addressed at a later date. Why are their needs not being addressed right now? As an association that has struggled to move away from diagnostic labels and eligibility criteria for service and has striven to focus on functional need, we cannot remain silent on the potential ramifications. To be clear, our position is simply, if a child needs physiotherapy, he/she needs physiotherapy and is therefore eligible.

Many children have multiple disabilities that necessitate coordination of services funded by different ministries. This is a system that can be managed, but with different ministries offering the same service on an exclusionary basis it becomes unmanageable. This only leads to game playing about which label to use today to secure funding and services for clients. We must not allow the long-term care reform to take us back to the days when interpretations were put on what came first, the physical disability or the developmental disability, and if the latter was determined to be dominant, service could be denied. We require your reassurance that this regression will not occur.

Our experience, when combined with these concerns for the status of children, fragmentation of the children's service system and discrimination, leads to one conclusion: Children's services must not be included in the proposed multiservice agencies.

We are requesting instead that the 1992 strategic priority given by the province to children's health, especially the goals to (1) "establish a more coordinated system of services, which focuses on children, youth and family," and (2) "develop effective, efficient and economical ways of improving and maintaining the health and wellbeing of children and youth," be aggressively pursued. It is recognized that in this time of so many competing needs this is not a small challenge, but given that our children are our future, it is a challenge that must be met.

As an interim measure to ensure that there is no break in service to any clients, we offer the recommendations contained in our position paper submitted in February of this year and attached to this brief as appendix H.

We also offer our full support to work with you to find the best solution for address of all our children's needs.

We thank you for your consideration of our submission.

The Chair: Thank you very much for your sub-

mission and for the various attachments that you've put there. We'll move right to questioning.

Mr Malkowski: Thank you for your presentation. It was very helpful for members to hear some of the points that you raised in your presentation. On one line or one comment that you made, that children's services should not be included under the long-term care MSAs, I asked a question of the minister this morning and she said that the legislation applies to seniors and to adults with disabilities, and does not include children. That was something she was very clear on this morning.

But another point I'd like to ask you: Currently, access to home care services requires a medical assessment and clients must meet very tight eligibility criteria. How do you think the one-stop access through the MSAs could help children and their parents? The criteria may become more flexible to allow adults with disabilities who need the home care. Perhaps you could just comment on those two points.

1610

The Chair: Just before responding, the parliamentary assistant wanted to make a clarification which might help in terms of the question.

Mr Wessinger: Yes, I'd just like to make clarification with respect to the whole question of the role of children under the MSA. I think it's quite clear what the position is. The MSA will continue to be responsible for the services which are presently provided to children under the home care program. I think that's probably all I should say to indicate there is no anticipated change in jurisdiction. In other words, there's going to be no giving up of any jurisdiction that's presently there contemplated under the legislation, although I might just add that certainly it's anticipated that in the interim, until we arrive at that time when we have a—I agree with you that we need to move towards a comprehensive system with children's services and I believe the ministries are working on that. In the interim, I understand it's anticipated that likely, for instance, services will be purchased by MSAs from children's treatment centres.

Ms Renahan: Can I respond now? If I understand the first point, and we've had the clarification that children are within the system, I would only expand on that in the case that it reinforces the point of why we're here. We've continuously forgotten that children are being impacted, and as I've had it explained to me several times, it's often because they are a minority and they are certainly going to be a minority in this situation, so they become forgotten.

I can also add to that in that we can hope by the time we leave there will be a change and they won't be included, so maybe the first statement would have been correct.

But the second question, if I understand it correctly, is how families can be helped through an MSA model, or just particularly with regard to children?

Mr Malkowski: For both.

Ms Renahan: For both? From the association's perspective, if I understand the question correctly, the children are entering due to the long-term home care

services that are going to be included through the children's treatment centres by and large wherever they exist, of which there are 20 of us across the province. It is in many ways already one-stop shopping and we just refer to the home care program to pick up the school health support and continue to provide the other components of the service to the children and families. So we don't see how that is going to improve for our particular clientele as a one-stop shopping perspective.

There is the other component of the acute care needs that are being met through home care, and we are presently not involved in that area of service, but in line with our support of single-access multiservice type of agency, we are quite prepared to consider and have communicated that in the past, to be prepared to take on, though with some apprehension, full responsibility for children.

Mr Malkowski: Okay, just to follow up, I'd like to ask a question with the policy people. I'd like to ask the policy people, what is the current system now, and then after MSA legislation is set up, what will be the benefits with the system? Will their criteria be more flexible, or what will be the changes on that?

Mr Wessinger: I will ask Mr Quirt, if that's all right.

Mr Quirt: I'm Geoff Quirt and I'm the executive director of the long-term care division. I'd be happy to try to answer that question.

Currently, children's treatment centres receive funding from a number of different sources, as it's been pointed out. With respect to the home care program, the home care program has two responsibilities for delivering health services to children: one responsibility where they are responsible for purchasing or delivering health services so that students can attend school, and as has been pointed out, sometimes children and their families are the home care program's clients with respect to the provision of professional services or homemaking supports when the children are at home as well.

The home care program's required to provide that school program all across the province, and in locations where children's treatment centres exist it's often the practice, and I think for about 50% of the expenditures on children, for the home care program to buy the services delivered to children at school from children's treatment centres.

This is one form of funding that children's treatment centres get. We also core-fund children's treatment centres from our division and we also know that those who are affiliated with hospitals receive funding from the institutional division of health as well.

I think the point's been made by our presenters, a point well taken, that under the auspices of the Ministry of Community and Social Services there is a review to look at how services for children can be best integrated across various disciplines. We are involved in those discussions with Community and Social Services, but we certainly don't want to see, as the result of the advent of multi-service agencies, children fall through the gap. So the intention is that multiservice agencies would assume responsibility for delivering the same range of services to

children that the home care program does now; in other words, serving them at home and at school.

It's fully expected that when delivering on that mandate, multiservice agencies may choose to purchase some of the specialised expertise that has traditionally been purchased by the home care program from children's treatment centres. As has been pointed out, it's conceivable that down the road, through the collaboration of the Ministry of Community and Social Services, Health, Education and others, there may be a better system that evolves for meeting children's services needs.

We want to be part of those discussions, and the mandate of multiservice agencies may change as a result of those discussions, but in the meantime, we want to make sure that the services that the home care program provides for kids now will be there through multiservice agencies.

Mrs O'Neill: I want to thank you for coming. I find this a very helpful brief. I want to ask you a couple of questions about your first page. You say you've been seeking active participation. Does that mean you haven't achieved the active participation you were seeking?

Ms Diana Thomson: I think we are really quite satisfied with the invitations to the various working groups that are currently in place, but we feel it's very important that the word get out, about more, bring to more people's attention the special and particular needs of children because they are a really rather small group in the context of this whole long-term care reform.

Mrs O'Neill: I don't know whether you've had a chance to see the most recent report of this committee. We've just completed a study on children at risk which I think was quite helpful. If you don't have the report, I'd certainly be happy to send it to you.

Ms Thomson: Thank you.

Mrs O'Neill: It would be of great interest to you, I'm sure. I found your appendices very helpful, from the Price Waterhouse one to the definitions of respite and special services at home. I think, as you say, many people don't know these programs. I'm also quite happy that you've put in your February 1994 submission.

I could say many things, but I am particularly happy that you touched on the developmentally disabled. I think there's a great possibility here to take many steps backward rather than forward, and not many people are talking about it, although the people who are in the field are talking. I'm glad you put children on the agenda of the committee on the first day, and I thank you for doing that.

Mr Jackson: I'd like to echo Ms O'Neill's comments because I support them with respect to getting them forward on the agenda. I can't help but think that one form of discrimination that you didn't list, but it's an equally—it's the school health support services program that, depending on which school you go to, you're discriminated against.

I remember that when I pursued this matter on behalf of one of my constituents who was attending a Dutch Christian school, the government of the day, which isn't this government, indicated that it was an education

program and therefore the government had the right to discriminate against a child who was attending a school that wasn't one of the two recognized school systems. Now I'm hearing everybody say, "Oh, this is a health program." It's very painful to hear that, from all sorts of people, in the last half-hour.

1620

But that discrimination still exists today in this province, and I'm fearful that those handicapped children will be further discriminated against in this setting, because I doubt seriously if the components of a purchase-of-service agreement allow for school boards to contribute, that in fact the policy of the day will continue, that MSAs will not be allowed to breach that provincial guideline and that we'll still discriminate against the child, regardless of their handicap, but on their religious beliefs, frankly, is what it ends up being, in almost all cases.

Would you like to comment a bit on that? I know you've probably come up against those cases, since you deliver a component of children with health needs attending school.

Ms Renahan: It's a good example of what we're trying to communicate, in the sense that what has been included in the MSA is very limited, it has a lot of limitations put on it and it's very focused on who it will deal with and when and how. What we're trying to advocate is that we exist to provide a much broader-based service or other children's services. It doesn't have to just be a treatment centre, but a children's system, because we do service the children with different religions in their schools. So in a sense the Ministry of Health is supporting, but it comes from a different program.

We also go into the homes. We also have children who are contracted with home care. We would send a therapist who is our staff into the school to deliver physio, but the child will come on an outpatient basis for occupational therapy to our facility, and it's going to be split even further.

Also, we're hearing the families say it can only be delivered from 9 to 3:15. Now, try to refer to that. These family needs go beyond school hours. We're also saying—and we're prepared, with support and dollars that could be transferred with it—we should be open in the evenings. We should be open on the weekends. That's when our families need the service, and they should be coming in to us. That's what a lot of them would like. So there's a lot of limitations that one example highlights about that whole program.

Mr Jackson: Could I ask Mr Quirt to consider reporting back to the committee? The other application that concerns me, for example, is a child with a physical disability requiring speech-language pathology, which is, quite frankly, a big mess in this province at the moment, with three different ministries fighting over who should or should not be delivering it, but these children are caught in that.

Are we to have faith in the system that the MSAs will leapfrog that and that they can then cut through that and say, "Okay, that child's assessed needs"—and I wish I had more time to discuss who is assessing children if

they're an employee of the MSA, when 94% of their case load are geriatrics. But having said that, are we to believe that the MSA's going to cut through this or jump above it and say, "Here's a child with a physical disability who's a pre-schooler," because the school board's no longer doing those programs, the hospital has cut off the program and Comsoc won't fund it, are we to now believe that there'll an envelope of moneys under the MSA to ensure that these children's services will be made available because they fit the definition? That's a very hopeful sign if that's in fact what will be achieved, because the government's been unable to resolve this in the last four years and service delivery's getting worse, not better.

That's a loaded question, and there's no secret about it, but there's a clear example involving thousands of children, and if that in fact is how we're going to deal with this, then great, give us more details; if it's not, then let's determine if these certain kids with disabilities are going to be discriminated against even further because some are going to get on one side of the line for funding and others aren't. I'd like some answers to that, and Mr Quirt maybe needs some time to consider the question and the presentation.

The Chair: I think as well it's an issue around how children fall or do not fall under this particular bill, which committee members are going to want to look at a little carefully. I will take that question under advisement. May I thank you all for coming before the committee today and for raising a number of issues.

Mr Malkowski: I'd like to make a request, Mr Chair, from the person—perhaps Comsoc could provide a briefing note related to the home care programs and how they are to relate to the MSAs.

The Chair: Thank you. Perhaps we can work that out with ministry staff and ensure that that is done.

CATHOLIC HEALTH ASSOCIATION OF ONTARIO

The Chair: I call our next witness, the Catholic Health Association of Ontario. I see some familiar faces that come before this committee. If you'd just introduce yourselves for Hansard, then please go ahead. We have a copy of your submission in front of us.

Mr Ron Marr: Good Afternoon. My name is Ron Marr and I'm president of the Catholic Health Association of Ontario. With me today on is Sister Alice McEvoy, who is a member of the CHAO board of directors, the chair of our association's long-term care task force and executive director of Marianhill in Pembroke, Sister Bonnie MacLellan is executive director of St Joseph's Heritage in Thunder Bay and also a member of our long-term care task force.

Our membership is diverse, but it has a common heritage and embraces a philosophy that recognizes that those in need of health and other human services also need the dignity of having their needs met on the basis of respect for their personal, cultural, faith, social and linguistic preferences. Our members, our employees, our volunteers and our care providers share a common sense of mission and a commitment to purpose that, among other things, fosters initiative and encourages innovation

without all of the constraints which often inhibit public sector providers of service.

The Catholic Health Association of Ontario supports the basic principles that are embodied in this bill: equity of services, increased access to services, and reform of the long-term care health system. We and our members have conveyed this message over the past few years as part of the government's review of long-term care. However, we cannot support Bill 173 because it is not, in our view, an appropriate reflection of the positions advanced at that time and will not achieve the objectives of long-term care reform.

The government is promising that this legislation will produce greater access and better services to consumers, the same promises which were made in advance of reform of the long-term care institutional sector. We must learn from the recent experience of what has transpired since reform has taken place in the institutional sector. What we now see is that the results of that reform are fewer beds, less funding and less staffing, and an increase in direct cost to the consumer of 47%. In light of this experience, it is difficult for us to accept bland assurances that this legislation will either increase the availability or improve the quality of community-based, long-term care in this province.

There are a number of issues which we would like to address this afternoon: (1) the destruction of community-based agencies; (2) the span of control of government bureaucracy through multiservice agencies; (3) the loss of mission, community support and volunteerism in the delivery of long-term care after Bill 173.

Prior to speaking to these specific concerns, I would like to address what we believe is a basic policy deficiency with this bill.

A key premise of this bill is the assignment to a single agency, the MSA, of the planning, funding and delivery of all community-based, long-term care services. The bill also entrenches the role of district health councils in the planning, funding and ultimately the delivery of services. It was our understanding, from the public consultations, that the major objective of the reform process was to improve the access, efficiency, effectiveness and ultimately the quality of long-term care. To the best of our knowledge, there is no research to demonstrate that the linking of planning, funding and service delivery will have this effect. Indeed, research has demonstrated just the opposite.

Research in Europe on similar monopolies demonstrated that this approach has been tried and abandoned. In a January 1994 paper, the Thames Valley District Health Council, one of the government's own official planning bodies, concluded: "Monopolies invite inefficiency and insensitivity to users. The provision of direct service by the MSA, could result in a loss of quality in the services delivered and a loss of incentive to maintain or improve the quality of service." They went on to state further: "We would like" to see "some assurance that this model (MSA) will work and that it isn't a model that other countries are moving away from. Publicly funded with contracted-out private service delivery appears to work best."

Turning now to our more specific concerns with Bill 173, I would like to ask Sister Bonnie to begin our presentation on how this bill will result in the destruction of community-based agencies.

1630

Sister Bonnie MacLellan: The Catholic Health Association of Ontario has a long history of providing institutional and community health services for the people of Ontario. Most of our facilities and services were initiated to fill the service delivery gaps in the delivery of health and social services in the community. If Bill 173 proceeds unchallenged, the tradition of denominational and cultural group sponsorship of long-term care services, both in the community and perhaps eventually in institutions, will end. In the process, we will lose one of the foundations of our cherished Canadian health care system and we will lose an established mechanism for providing value-based safe, efficient, effective, holistic and compassionate care.

The major concern raised by both consumers and providers of long-term care was ease of access to a myriad of community health services. With the introduction of Bill 173, the government has determined that the solution to the problem of access rests solely in the arena of planning and management, ensuring that all planning and management is not only coordinated but accomplished by a central bureaucratic structure, the multiservice agency.

This bill goes beyond supporting MSAs in the planning and management of long-term care and community services. Bill 173 assumes those who plan and coordinate services will also employ professional, paraprofessional and support staff to provide these services. This is clearly an implementation and expropriation bill that will disband local community health and social service agencies, which have a long history of meeting the needs of the people in the community, and replace them with large, impersonal, regional bureaucracies. Charitable, non-profit providers are being told by this government: "Thank you very much for all that you have done for the people of Ontario for over 200 years or so. We're glad you could provide these services when we needed them. Now we think we, the government, can take over and be as efficient and as effective as you have been in the past. Your presence is no longer required."

Most people in this province, hearing this claim, would be appalled. With all due respect, there are few if any who would associate the adjectives "efficient" and "effective" with anything associated with government. While the spirit may be willing, the flesh is indeed weak. Show me those public services controlled solely by government that are more sensitive to consumer needs than to political and fiscal agendas. I'm from Thunder Bay, far away from Queen's Park. While I have a lot of faith in some areas, this is one in which I'm siding with Thomas. I challenge you to prove to me that the dismantling of the entire long-term care and community health care system will indeed improve the delivery of compassionate care to people in communities.

Mr Marr: I'd like now to ask Sister Alice McEvoy to address our second concern, which is the span of

control of government bureaucracies through the establishment of the multiservice agencies.

Sister Alice McEvoy: Bill 173 is being promoted on the basis that it deals with the issues of access, coordination and integration of essential community services. Using these goals as a smokescreen, the government is attempting to position this bill as a consumer-driven initiative. We would argue that most consumers, real consumers, are not aware that criteria will be put in place which will actually limit their access.

There may be one-stop shopping, but consumers are not aware that choices will have to be made between the provision of health services and social services as they will all come from the same spending envelope. An individual's needs may have little to do with the level of care provided.

Consumers are also not aware that this bill will serve to constrain the development of new and innovative initiatives within our community, such as we've done in Pembroke with the community Alzheimer society.

Under the current system, the public has a choice in the services they receive and from whom. Under the new system, MSAs will absorb existing community services, including those that are now delivered by charitable agencies such as the Red Cross, the Victorian Order of Nurses, and the St Elizabeth Visiting Nurses, and take away that ability to choose. We do not believe that our communities and health care consumers will be better served by the elimination of the freedom of choice.

Under this legislation, the MSA will become a very powerful and centralized agency rigidly controlled by the provincial government. Through MSAs, social service providers will be competing for health care dollars. Acute health care needs in the community are constantly increasing due to shorter hospital stays. These needs can drain available resources away from other services, both health and related social services. The result may be fewer overall services for the MSA clients. Choices will have to be made which may have little to do with the individual's need and more to do with balancing costs.

The introduction of MSAs as proposed will also inhibit the innovation and development of new services. In the absence of competition, multiservice agencies will become monopolies, organizations known for their tendency to get bigger and more expensive, just as they are known for their inability to innovate and excel.

The consolidation and absorption of all community-based service organizations into an MSA will reduce the efficiency and effectiveness of those services now offered by charitable organizations, without bringing these services closer to the community. One of our major ties to the community is through our volunteer boards. Under this legislation, they will be replaced by large regional provincial bureaucracies directed by a handful of government appointees.

Charitable community non-profit agencies do not generate profits through their endeavours, nor do they have government's seemingly unlimited capacity to incur debt. By any standard, the administrative overall cost of charitable agencies is low. Funding in the future and,

perhaps more importantly, the effectiveness of that funding will become an issue.

As community agencies are merged into the provincial bureaucracy of the MSA structure, each agency's staff will be absorbed. With this will come the pressures of unionization. Salary and benefit costs will inevitably escalate. Many community-based workers with a significant long-term commitment to this type of care could well find themselves out of work once the MSA is established.

Transitional funding is being promised along with this legislation. No doubt the government will point to these expenditures as an example of its commitment to long-term care. However, these funds will in large part be consumed by labour adjustment, retraining and administrative costs in order to set up these new bureaucracies. None of these precious long-term care dollars will have been used to provide new beds or new funding for additional home care services.

We believe you can easily address the objectives of one-stop access and the coordination and integration of services without eliminating community-based charitable organizations. Instead, the government has chosen to establish itself as the sole provider of long-term care, thereby trying to ensure the equity and availability of services, if not the excellence of those services.

Through this legislation, quality, creativity and innovation in long-term care will be stifled in exchange for rigid control and whatever limitations the government may feel compelled to impose. We do not believe that the interests of consumers will be better served by the inflexible delivery mechanism that will be imposed by this legislation.

1640

Mr Marr: For our last point, Sister Bonnie will speak to the issue of the loss of mission, community support and voluntarism in the delivery of long-term care after Bill 173.

Sister MacLellan: In its discussion papers that preceded this legislation, the government attempted to address the issues of vision, mission and commitment that drive charitable community-based organizations such as those which make up the membership of the Catholic Health Association of Ontario.

In its document *Partnerships in Long-Term Care*, you assure consumers that they can ensure "some services do not lose their individual identities as they become part of the larger MSA organization, especially if this individuality is important to consumers." The document goes on to suggest that "the use of identifiers such as a service name, logo or service location," once amalgamated under the MSA, can retain their individuality. Nothing could be further from the truth.

I suppose I should be grateful that through this statement the government recognizes the role that values and tradition play in charitable human service agencies. What the government seems not to understand is that the passionate commitment of our staff and volunteers to the philosophy and values of these health care organizations are not the product of service names and logos or service

locations. They are the product of our heritage. They are the product of having the hearts of our employees, our boards of directors and our volunteers captured by the vision of providing value-based and -driven holistic care, meeting physical, social, emotional and spiritual needs. These fundamental elements form the foundation of the services of the Catholic Health Association of Ontario and are not transferrable to the MSA. How do you transplant the heart of an organization into a bureaucracy? It cannot be done.

In terms of the commitment of our volunteers and those who support our fund-raising efforts, a significant proportion of our operating costs is offset by the efforts of the communities that support us. The government assumes that this volunteer support will continue to accrue to the benefit of the MSA bureaucracy. It is highly unlikely that this will be the case. Long-standing support for a community-based organization is generally just that: support for that specific community-based organization, its philosophy, its values, its mission and the founder's heritage. It is not the support for the general service itself. If we look at other rigidly controlled government services, it is difficult to understand how the government can claim that the existing level of voluntary commitment can be maintained.

Our members have been on the front line of human service delivery in this province for more than a century. Inspired by our historic roots and traditions, our member institutions have been leaders in designing, expanding and improving programs and services. Catholic health and human service providers respect the dignity of those we serve by recognizing their desire for services that are based on personal, faith, cultural, social and linguistic preferences. We only ask that our legislators now do the same.

Mr Marr: Just a final few comments, Mr Chairman. In conclusion, the Catholic Health Association of Ontario does not believe that the interests of consumers nor the interests of the public at large are better served through the elimination of the freedom of choice that results from this legislation. We believe that the proposals put forward by the government in this legislation are lacking in many basic elements which are vital to a properly functioning long-term care system. A lack of general public awareness exists regarding the effects of this legislation, and this has led to an overall lack of informed input and consultation. Only those who are plugged into the system have really been involved in this issue, not the people who actually need the care.

We do not believe that this province will be better served by the destruction of community-based volunteer boards in favour of a large bureaucracy directed by a handful of government appointees. We must be cognizant of other jurisdictions which have proceeded in this manner and have not been successful.

The enlarged health care bureaucracy created through this legislation will not attract the volunteers and the private donations that now augment the services provided by charitable community agencies. Without these funds and people we would be unable to provide the level of services we currently do. What will this mean for the

level of available services in the future?

Finally, this bill does not guarantee that either the efficiency or quality of long-term care in this province will be enhanced as a result of its implementation. As we acknowledged earlier, changes are required; however, we should be sure the changes will bring about improvements to the system before they are implemented. We believe that the important goals of the reform of long-term care are in danger of being lost unless this legislation is modified significantly. Thank you very much.

The Chair: Thank you very much for your submission. I'm going to have to play the heavy as Chair and just note that we have a problem with time. I can allow one person from each caucus to ask questions. We could probably be here quite a bit longer, but I'm afraid we have a problem. I have the parliamentary assistant, Ms Sullivan and Mr Wilson.

Mr Wessinger: I was interested in some of the statements made. First of all, it should be indicated that there's a misconception about the planning being part of the MSA function. That's not accurate. The planning is part of the district health council function and not part of the MSA function.

Second, in view of the fact that MSAs are going to be non-profit corporations, in view of the fact that their membership will be open to all members of the community, in view of the fact that they will have people elected, I assume, like any other non-profit corporation, to the board, with the election undoubtedly to meet certain criteria of consumer and provider requirements, and in view of the fact that in many ways this type of structure will be somewhat similar to what we have in many hospitals—and if we look at the success that the hospitals have with respect to fund-raising, with respect to volunteers, we see they have a great deal of success—therefore I'd like to ask you on what basis, in view of the fact that we're in effect having a community equivalent to a hospital, with a charitable status, a non-profit status, local input, why you feel this is going to be a large government bureaucracy.

Mr Marr: I think I'll answer that one. I'd like to start out by clarifying one point for Mr Wessinger—and I think we've been in this debate in the past—that there are significant differences between hospital corporations and the MSA. Hospitals are charitable, not-for-profit corporations, you're correct, but that's what exists today with individual agencies such as Saint Elizabeth Visiting Nurses, VON, Red Cross etc.

What's being proposed in this legislation is very different. It's one agency. There will be one game in town, where all agencies will lose their identity and will become one government-run and government-controlled bureaucracy. It's very different from hospitals that have unique and individual missions and enter into purchase-of-service agreements with the government.

Mr Wessinger: No. I can understand your concern about your own organization's individual existence, but it would seem that in many cases—for instance, in many communities you have one hospital. Other communities have more than one hospital, but the trend has been towards, as we see what's happening in the Windsor area,

the hospitals getting together and forming one type of joint management process. It seems there's very much an equivalent between the institutional sector and the community sector.

There's certainly a major difference in the model that's proposed here from the Quebec model. You're quite right, the Quebec model is a government-run—well, maybe not. It's a different type of model. It's certainly not based on the non-profit, charitable model, which is of course the basis of the MSA. The MSA, being a charitable, non-profit corporation, would be able to elicit donations and seek donations and would be seeking volunteers, the same way a hospital does. I have this difficulty in understanding the perception of the MSA as—it doesn't fit the centralized model. It's certainly not centralized from a provincial basis, anyway. It's really a community-based model: one organization, I agree, but a community-based one.

1650

Mr Marr: Our concern is not so much with the objectives of the MSA. Everybody appearing before this committee today has probably said the same thing in terms of reform of long-term care. Where we're having some difficulty with this is in the methods to achieve the objectives. We do not believe that disbanding existing expertise and putting everybody under one umbrella is going to achieve the objectives that are being stated for long-term care, any more than in the hospital sector merging two hospitals is going to result in efficiencies that everyone thinks are there.

I see Mr Martin from Sault Ste Marie here, for example. There's an experience in Sault Ste Marie where two hospitals have managed extraordinarily well to come together and achieve many of the government objectives and everybody else's objectives in terms of hospital care without merging the two hospitals, with maintaining two distinct identities and being true to the heritage of both facilities and offering the highest quality of care.

The merger of institutions or agencies does not always result in the objectives that are being suggested for long-term care reform. That's the basis of our concern.

Mrs Sullivan: I too am concerned with the disappearance of the mission-based facilities and agencies that we see as a direct result of the new multiservice agency concept. I wonder if you could speak in a quite directed way with respect to the canon law base of the Catholic health care organizations' missions and mission statements and what effect the canon law requirements would have ultimately if the MSA is formed and the Catholic agencies' existing missions are not met through the MSA. What would be the position of the Catholic health care organizations? Could you participate, or are we indeed looking at simply a new employer and all the Catholic agencies are gone by the board?

Mr Marr: I think this goes beyond a Catholic issue and an issue of canon law. What we're talking about—

Mrs Sullivan: I understand that, because we will have other agencies that are Salvation Army agencies or Anglican agencies or Jewish agencies that are affected by this particular situation. But in hospital discussions, one

of the things there has to have been extreme care about is to ensure that the canon law requirements are met in terms of joint management or participation in any kind of joint venture. That's what I'm getting at here. I'll have other questions for the other religious organizations with respect to their missions and how that will be maintained and ultimately integrated.

Mr Marr: The basic principles of canon law, when applied to a health institution or facility, generally imply that in order to maintain the mission and values of that community-based or institutional-based service, the only way you can guarantee that is through direct governance of that institution or community-based service. Once you remove the governance, the ability to govern that institution, which will happen under this legislation to every community-based agency, not just Catholic community-based agencies, that mission is lost, it is then a new institution. In terms of Catholic providers, we could not continue with that, and I don't think any—you may call it the VON or you may call it Saint Elizabeth's, but it isn't. It's an MSA program.

Mr Jim Wilson: When I studied canon law, I wish I had paid more attention to governance matters. It seems to me it would be a question of conscience indeed for not only employees of Catholic institutions but previous governors of Catholic institutions also. I mean, if they're going to take the crucifixes down from the walls and water down the program totally and take the ethos out, I can't see why any of the denominations would want to be involved in it.

Second, the parliamentary assistant's comments were extremely misleading. I don't think we're reading the same bill, Mr Wessinger, because you are gutting these institutions. As I said earlier, either you're bringing in a big bureaucracy to put on top of existing agencies—you tell us you're not doing that, so second, you're bringing in a bureaucracy and these other agencies will have to give; I mean, they'll be dissolved. You can't have it both ways. Your bill's certainly designed to bring in a bureaucracy. I just can't picture anyone fund-raising for an MSA.

Mr Jackson: I already pay taxes. Why would I give to an MSA?

Mr Jim Wilson: The Premier just isn't that popular, nor can I picture people volunteering for the government, goodness knows. Look at our own bloody polling on these issues. People are trying to get away from government, and look to sectors such as the Catholic Health for the delivery of services.

It's an astounding presentation you've made and it follows on the press conference you had. You've used extremely strong words: "expropriation," the "elimination" of denominational services such as yours in governance. I know you've had a lot of months in working with the government or at least talking with the government—maybe it was one-sided. I want to know, given that we understand from our briefings that you were consulted along the way, and other denominations were, now that Bill 173 appears in its present form before us, what's your opinion of the process?

Second, I just want to read for you an excerpt. I think

the minister, doing damage control from your press conference today, has issued a press release. It's kind of happy, but there's a line in it, a quote from the minister saying, "The values and traditions that caring volunteers have demonstrated for many years in this province are at the heart of changes in long-term care." She's directly challenging the statements you've made, both in the press conference and here. I think there was some scepticism of members of the press gallery too, and I suspect you got the point across rather powerfully when they persistently asked, "Give us an example of how this will gut your institutions and how it will discourage volunteers."

I want to talk about the process at this point, because I don't ever want to see it happen again in this province—I've had enough of it—and second, with respect to volunteers once again.

Mr Marr: I'll try and answer what I think you're asking. We have been involved for the last two or three years in discussions around reform of long-term care and we have participated actively, and I hope that various constituencies have heard what our member institutions and community agencies have been saying. Why we're coming out now: We are not saying anything different today from what we have said for the last two and a half years, in terms of, if you go forward with MSAs this is what you're doing to community-based agencies.

My concern, quite frankly, is ultimately to institutional care as well. If you get the community agencies under the umbrella of the MSA, two years down the road maybe it's time for the homes for the aged to be brought under the MSA umbrella; maybe two years later it's time for all hospitals to come under the MSA umbrella. We don't know.

We've been saying this for two and a half years. Why we're coming out strong now is because the legislation has now been tabled. The messages we've been giving and that other agencies and groups have been giving for the last two and a half years are not reflected in this legislation. We've had since, what, June 3 or June 6 or something since this legislation was tabled, to prepare this response. There's nothing new in here; we've been saying this for two and a half years.

Mr Jim Wilson: The minister doesn't believe that your volunteers will be affected. Do you want to try one more time?

The Chair: This is the last question, please.

Interjection.

Mr Jim Wilson: Well, she challenges them. It's absolutely astounding.

Ms Jenny Carter (Peterborough): Seventy thousand people were consulted, and we're being told that there was no consultation?

Interjections.

Mr Jackson: Did you go to one of those meetings?

The Chair: Order, please.

Interjections.

The Chair: Order. Please allow the witness to respond, and I'm afraid this will have to be the last response.

Mr Marr: I think the question was the impact on volunteers and on service agencies. There are two agencies following us after this presentation that I think can talk to you much more specifically about these particular issues than we can at this time. Maybe you can ask the same question of Saint Elizabeth Visiting Nurses' Association of Ontario and Catholic Charities of the Archdiocese of Toronto.

The Chair: Thank you. I'll just jump in quickly before exuberant members get going. Thank you very much for your submission and for coming before the committee today.

SAINT ELIZABETH VISITING NURSES' ASSOCIATION
OF ONTARIO

The Chair: I call on the representatives from the Saint Elizabeth Visiting Nurses' Association of Ontario. I just note to committee members that we are running about half an hour late. I apologize that we can't have everyone's questions, but we will try to cover as much ground as we can with the next two presentations.

Ms Shirlee Sharkey: Mr Chairman, members of the committee, I am pleased to be appearing before you today to present the views of Saint Elizabeth visiting nurses' association regarding the government's legislation to establish multiservice agencies. My name is Shirlee Sharkey and I'm the president and CEO of Saint Elizabeth, and with me are Joel Rochon, the chair of our board, and John Burns, a board member.

Saint Elizabeth has provided quality home nursing services to the residents of Ontario for over 85 years. We employ over 800 staff. This year we served over 13,500 residents and made over 600,000 visits to the regions of Peel, Durham and Metropolitan Toronto. We have provided teaching for over 500 nursing and medical students this year alone.

Our values come from origins in the Catholic community, but we provide professional care to Catholics and non-Catholics alike and specialize in working with a variety of ethnic cultures. Over 66% of our clients are senior citizens. Our mission is very simple: We are committed to providing integrated nursing and related health care which meets the physical, emotional and spiritual needs of both clients and their families in their homes and communities. We have an independent volunteer board of 18 members which governs our operations.

We are responsive to and reflective of the communities we serve. Saint Elizabeth is an organization which provides innovative services and programs such as gerontology, psychogeriatrics and an elder abuse protocol. As well, we provide palliative care, renal dialysis, paediatrics, mental health, respiratory and chemotherapies. We care for each person on an individual needs-driven basis in their own home. Emphasis is placed on illness prevention and teaching individuals and their families to assume responsibility for their own care. All of this work is done in-home by way of a locally sensitive community-based system as opposed to the proposed large MSA bureaucracy.

For the most part, our clients are referred to us from physicians through home care. This latter organization

evaluates a client's eligibility, assesses need and arranges for Saint Elizabeth's. This system is not perfect, given the limited mandate of the home care program. In this respect, Saint Elizabeth agrees with the sections of the bill which aim to improve and broaden access to important long-term care services.

However, while we support the commitment to access and also to the patients' bill of rights, it is our experience in community-based health care over the last three quarters of a century which makes us so concerned about some of the proposals contained in Bill 173. We believe in the community-based approach which this government has been promoting and applaud many of your initiatives in this area. However, aspects of this legislation are of great concern to us.

The proposals contained in Bill 173 will lead to an unknown number of multiservice agencies. While the MSAs will be allowed to contract out some of their services, they will be limited to 20% of total services. The MSAs will take over current well-functioning organizations and absorb them into one agency within that geographic area. Ironically, the resulting duplication of community health services runs counter to one of the stated goals of this legislation: lower costs.

For example, if all of the nursing services currently provided are offered by individual MSAs, our calculations indicate the proposed establishment of up to 20 MSAs in Metro Toronto alone will cost taxpayers an additional \$7 million in order to support just these nursing services.

The proposed changes also mean that long-standing service organizations will lose their individual focus and identity within their communities. Clients will no longer have the ability to choose a specific organization for their care. Many worthwhile organizations with established standards, efficient operations and a critical mass of highly trained and responsive health professionals will not be used to provide necessary services. Many of Saint Elizabeth's workers will lose their jobs and will have to apply for new positions in the MSA, and the volunteer element will be removed from our organization. All of these items will dramatically affect the ability of the MSAs to provide adequate and appropriate services, since it will be impossible to replicate Saint Elizabeth's specialized professional service in each MSA. We believe these changes will impact negatively not only on our clients, but on the system in general.

The changes being proposed would remove our individual nature and replace us with a faceless government-mandated agency. One of the most positive features of Saint Elizabeth's is that we are part of the community, we know the community and we are supported by the community. People know we will provide care enhanced by our respect for cultural and religious beliefs. These features provide a more responsive and caring service, the type of care we should be moving towards, not away from.

The choice of agencies to provide services will not exist if MSAs are established as currently outlined. As we understand it, the individual will be referred to one service provider, the MSA, which will provide all the

required services. This obviously precludes the client's choice of accessing services from existing agencies.

We do believe that some of the provisions of Bill 173 could facilitate consumer choice, specifically those which establish a single access point for determining the availability of required services and the options which exist. This is the role that government and government-mandated organizations should play, to determine eligibility and access to the system and establish program standards. But it is here where the activities of the MSA should stop. The delivery of professional health services should continue to be the responsibility of the well-functioning organizations which currently exist. They should not be provided by government-mandated organizations which have taken away the identity of the agencies they have absorbed.

As currently outlined, MSAs will become the major community employer of health professionals. What will happen to Saint Elizabeth's non-unionized professionals? Indications exist in some government guidelines that unionized employees will have the first opportunity for available jobs. This will place Saint Elizabeth's workers and other non-unionized workers at great disadvantage. In our view, this is an unacceptable situation for hardworking, skilled and devoted employees of organizations or groups like ours.

The Minister of Health must ensure that non-union staff have protection similar to that offered to unionized staff under the Labour Relations Act, but more importantly, the Minister of Health must be concerned regarding the quality of workers. The skill, quality and commitment to community health care that exists today is not easily or cheaply replaced. Rather than absorbing independent organizations, increasing financial costs and making them part of the government MSA system, these organizations should be retained to allow the provision of the best and most cost-effective services possible.

1710

Currently, Saint Elizabeth is supported by hundreds of volunteers, enabling us to efficiently run our operations and devote funds to providing care to clients. With MSAs, virtually all volunteer time and financial support now contributed to charitable agencies will disappear. It is highly unlikely that volunteers who support Saint Elizabeth's will continue to support a bureaucratic structure which is taking away the individuality of the organization they believed in. People choose to volunteer and support individual organizations due to their values and personal experiences. We doubt that this bond will be developed with a government-mandated MSA.

We at Saint Elizabeth's agree reforms need to be made to the long-term care system and we have been an active participant in the government's review of this matter over the last number of years. Changes are particularly needed in the area of accessibility to and knowledge of available services. However, it is possible to achieve these reforms without changing the entire system and eliminating much of the good which currently exists. We believe that it is still part of our social fabric to have volunteers continue in their role of helping others in their communities. Support for services such as those provided by Saint

Elizabeth shows that many others believe this as well. This is not the time to water down home care by simplistically blending social and health services and forcing choices to be made between them as if there is no difference. This will only hurt the people we are trying to serve. This is the time to be supportive of those independent community organizations which are successful and try to replicate their activities across the province.

Rather than devoting millions of dollars towards taking over and running current agencies such as ours, why not target that money to promote the development of well-thought-out community-based organizations? Why not put a system in place which will provide real one-stop shopping and easy access to service information without having to provide the actual services? This should be the role of the MSAs: to establish criteria, ensure equity of access. These actions would be much more beneficial to the people we are trying to help, the clients and their families, than the proposals currently on the table.

While we support the principles of long-term care reform, the role of the MSA should not be to provide services. The elimination of non-profit, ethnocultural agencies that are efficient and well managed is not only wasteful but unnecessary. The replacement of these professional health care organizations with the proposed MSA structures will cost the taxpayer more and will deprive clients of high-quality care given by well-trained specialists. It will also eliminate individual choice, thus interfering with personal liberty, and as we all know, the price of liberty is eternal vigilance.

We urge this committee to exert that vigilance in considering these factors and to take the necessary steps to put in place a long-term care system which will really serve the needs of the people of Ontario.

The Chair: Thank you very much for your submission. We'll move right to questions.

Mr Malkowski: Thank you very much. Interesting presentation. I think it's important to clarify, if we could just touch on some of the facts, that MSAs are not a bureaucratic system. They are and they will be run by the community-based agencies that are out there.

I just wanted to ask a question. You are saying that choices might be limited and, "You're going to remove choice to individuals." I want to be clear that I believe it's actually going to be an increase in personal freedom and choice. I believe there will be an increase as a result of long-term care.

But let me ask you a question: Right now planning is happening across the province. Can you tell us how Saint Elizabeth could be involved to date and what they have been doing in the local district health councils?

Ms Sharkey: I'd be pleased to respond to that question. Saint Elizabeth has been actively involved in the last two and a half years with the reform of long-term care reform, at the DHC level, both on the long-term care steering committees and on the MSA design working committees.

We have voiced the same concerns today at the DHC over and over again and have clarified the specifics of the concerns with the service delivery aspect of the MSA

model but have also been clear about the other aspects that we support.

We have also, at the local level, throughout all of our years, been very involved in community involvement. In Metro Toronto alone we are involved in 18 of the planning consortiums for MSAs and in Peel and Durham have been actively involved. We also have been involved in the York region, where we have currently expanded our services, and in the Kingston region.

Mr Malkowski: Just a quick supplementary. Could you tell me or give me an example then, where you talk about the limitation of choices, where you believe that choice will be eliminated, if you strongly believe an MSA would do that? I believe it actually will increase our range of options. Could you give me an illustration of how you think one's choices might be limited?

Ms Sharkey: I'd be pleased to respond to that. We have, with our program in the areas that we service, the ability for anyone in the home care programs to ask for Saint Elizabeth nurses or the Victorian Order of Nurses as a choice of service. During that opportunity, many may choose to have one or the other agency, based on preference, history and even some of the unique programs that we currently provide. My understanding with the MSA model is that Saint Elizabeth's and VON will not be around for the client to choose either one of those agencies, and that is quite clear, from our perspective.

Mr Malkowski: May I ask a follow-up of the policy people? If in fact these comments are based on reality, is that true, that the Saint Elizabeth and VON won't be under?

Mr Wessinger: I think what the member is asking is how the process works at the present time, and I think the staff could probably indicate how it works with respect to the home care being provided.

Mr Jackson: It's not a process question, it's an outcome question. Will it happen? Yes or no.

Mr Quirt: I think it's fair to say that across Ontario now MSAs are being planned through the DHC planning process, and in some communities it's conceivable that the nurses who now work for the VON or the nurses who now work for Saint Elizabeth would become part of the multiservice agency.

Mr Jackson: Employed by.

Mr Quirt: And employed by.

Interjections.

The Chair: Order, please.

Mr Quirt: That's a distinct possibility. It's a distinct possibility that many other—

Mrs Sullivan: On the other hand, they might not get a job.

Mr Quirt: It's quite possible that in some communities an existing Victorian Order of Nurses branch or an existing agency currently, like a home support agency, may be seen as the logical provider of the MSA services and in effect workers would be transferred to that organization as opposed to those workers going elsewhere.

There's no question that this is a disruption for those

employees who are now employed by over 1,000 long-term care agencies across the province, and it is an organizational change that's difficult for many people to cope with and to move forward with. But I think the objective is to create a system that's more integrated.

Right now, we have over 1,000 agencies that deliver long-term care services in the community. We heard from consumers that this is too many agencies. We heard that it's difficult to have to deal with four or five agencies to have four or five different needs met and, quite frankly, consumers told us that they'd rather go one place and have one agency equipped to meet their needs in a more flexible and comprehensive way rather than deal with a number of organizations.

In recognition of the fact that it will be difficult for workers and organizations to make this transition, the bill allows for the designation of a multiservice agency with a period of up to four years for that type of adjustment to take place. In terms of a period of four years within which the 20% service limit may not be applied, the minister can exempt the MSA from that requirement or the minister can exempt the MSA from delivering all the mandatory services indicated.

We recognize it's a difficult transition. It has to be planned locally. I'm pleased to see that your organization is involved in the planning not only here in Metro but in other parts of the province, and we're pleased with the advice you've given us on the provincial advisory committees as well.

1720

It is a fundamental organizational change. We believe it's one that's necessary and we believe it's one that will result in better service for consumers across the province.

Ms Sharkey: If I could just clarify on a few comments, Geoff. One, I do appreciate your concern about the difficulty of the workers, and we do also. But our concern goes far beyond that. It's the quality of care that will be compromised in the system if in fact the workers are not used in the MSAs, and the retraining costs and the educational costs, which is another issue where we've not received a response regarding unionized and non-unionized employees.

In addition, the comment about 1,000 agencies providing services, let me be perfectly clear: From the health agencies in the system, there are less than a handful of professional health agencies. In the areas that we provide care in Metropolitan Toronto, with 2.2 million people, there are a handful of community health providers; in fact, less than a handful of community health organizations. So let's be very clear when we collapse all of the agencies into one analysis of thousands of agencies.

Ms Carter: Could I have a point of clarification, please, I guess from Mr Quirt. You say, and obviously it's true for Metro, that people you serve have the choice between VON and the Saint Elizabeth nurses. I'm just wondering how general that is across the province. I understand that in most places, there would be one or another of these agencies; there would not be a choice in practice in most circumstances.

Ms Sharkey: That's in fact what we are proposing,

that more community agencies be allowed to be accessible throughout the province so that the comprehensive services we now provide with Saint Eliz and VON can be offered province-wide. In fact, some of those services are extremely limited in areas where there is only one provider in the system. So that's very much what we're trying to encourage.

Ms Carter: But I understand that home care organizations would often have a contract with one of these groups only, so that, in effect, their consumers would automatically receive a nurse from that organization rather than having a choice. Could you confirm or deny that?

Mr Quirt: Certainly you're quite right that in terms of accessing publicly funded services in your own home, like a publicly funded nursing visitor, homemaker visit, there is one place you go, and one place only, to have that decision made currently, and that is to the local home care program, of which there are 38 province-wide. So in terms of choices, to go talk to someone who decides whether you're supported by the publicly funded system or not, there is one place to go; there is not a choice in that regard.

In many parts of Ontario, your second observation is also quite accurate. In rural Ontario in particular, there may well be circumstances where there is one contract for nursing service or perhaps one contract for home-making. In many parts of Ontario, there is the choice that the home care program can exercise among a variety of providers, but in rural areas in particular there is not a large number of agencies from which a client could choose to be served. As I pointed out earlier, there's one place where you go to have it determined whether you're eligible or not in the first place.

In many parts of Ontario, you would have the one home care program to go to, to have it determined that you were eligible to receive either nursing or home-making services. There may be one or more nursing or homemaking agencies that would serve you at the discretion of the home care program, and it's conceivable you might receive a Meals on Wheels service from another agency, a transportation service from yet another, and a friendly visit from another home support agency. I suppose you could look at that as a choice, but you certainly wouldn't have a choice of two home support agencies to choose a meal from and you would be having to deal with, on your own, those five agencies to coordinate the full range of service that you needed.

The Chair: Sorry, did you want to make a comment?

Mr Joel Rochon: Yes.

The Chair: Please do so and then, just to committee members, we must move on to Ms Sullivan and Mr Wilson.

Mr Rochon: I just want to say that when we're talking about choice here we're not talking about an insignificant group. We're talking 48% of the citizens of this province say that their religion is Catholic. I mean, half the tax base comes from these people. So if you have a cancer situation and you feel that you're dying and you want palliative care, you might want a choice of who is

delivering the palliative care in your home. That being the case, maybe it's conceivable that half the MSAs should be Catholic in origin, because that represents the community.

What is the definition of community here? Is it geographic, as this organization says it is, or is it the Italian community, the Greek community, the Hungarian community, the Jewish community, the Anglican community, the Catholic community? Maybe that's another definition which would very significantly change the shape and form of this organization.

I suggest that the organization is very simplistically designed, and it's designed to say that the best way to do this is to have a bureaucratic—and no one likes that word, I know, in this room—organization to run it all. I think that's insensitive and, by the way, flies in the face of the objectives of this initiative in the first place, which said that it was going to be spiritually, culturally sensitive. It is not.

Mrs Sullivan: That's a very eloquent summation.

There are two points that I want to raise in my questions. The first is with respect to what Mr Quirt calls the disruption of the existing employee base. That disruption is going to be not a disruption that's calm. It will be tantamount to a revolution. There'll be severance issues—who pays; there will be succession rights; where is the non-unionized worker in relationship to the Labour Relations Act; there'll be the question of job guarantees and promises which have been made to agencies; there'll be the question of where the funding comes from for retraining; there'll be the whole question of what happens to the, I think it was 5,000 nurses we know of who have been displaced from hospitals during restructuring who've been told that their new places are in the community agency.

Those issues I think have to be addressed and we're going to have to turn our mind to it. If you want to comment further on that during this dialogue, that would be useful.

The other issue, though, that I want to ask a particular question about is with respect to the 80% of services which the government now says will have to be provided by the new multiservice agency. If 80% of those services which are now provided by community-based agencies such as your own are provided by the new agency, that means that the services which you offer will be depleted by 80%. Some of the services that Saint Elizabeth's offers are above and beyond what are required mandatory services in this bill, and you've delineated some of them in your presentation, not the least of which are dialysis services and home chemotherapy and so on.

Will Saint Elizabeth's be able to sustain the provision of that other 20% of services if your government-funded base is taken away from you to the tune of 80%?

Ms Sharkey: Absolutely not. Some of those other additional programs are our palliative care volunteer program, which is completely funded and supported outside of government funds; also our bereavement program, where we receive additional funding from Catholic Charities and ShareLife. In addition, many of

our specialty programs—our mental health program, our home chemotherapy program—received enhanced contributions in funds to provide the educational support through our own charitable status. It is with those additional costs and value added in the system that we feel we are able to provide a very cost-effective approach to the services that, quite frankly, no government can afford at this point.

Mr Rochon: May I have a supplemental?

The Chair: You're in the right place.

1730

Mr Rochon: I'd just like to speak about critical mass. The reason that Saint Elizabeth is such an excellent organization with its specialties in palliative care and oncology and in-home chemo and the rest of the thing is that they're able to train specialists among their group. If you take that group of 800 and you divide it by 20 times, you lose the critical mass and the ability to develop and sustain that professional confidence. The person who suffers as a result of that lack of critical mass and ability to train is the patient, the citizen of the province you're trying to serve.

What is wrong with going into the MSA organization as a point of call, the 911 sort of number, and then having organizations like Saint Elizabeth, representing a very important constituent in the province, provide those services in an efficient, flexible way?

In business it's well known that you can either have things in-house or contract them out. In our case, we have delivered those services against government-provided standards as to cost, and you know what you're paying. What will happen to those costs in the new mode, when you don't have that contracting piece? You all have homes. Would you sooner have someone hired on an hourly rate or would you sooner have a contract rate? You want a contract rate because you can manage it.

You are responsible for managing the fiscal resources of the province. Are you doing a responsible job of that when you do away with professional services such as this and the contracting that allows you to control costs? How do you go to your voters and say, "We've done a wonderful job with this"? Or is it really just a political agenda being played out here? You have to ask yourself that.

Mr Jackson: Well, there's no question, Mr Rochon, that it is a political agenda. I think both your comments and Ron Marr's, who preceded you, have indicated with some of your comments—I can't help but say that how you were describing what would be a wiser approach for the MSA, and Ms Sharkey had also said that as well, was in fact what we were discussing in this province for the last six years and it's exactly what our public consultations were built on. These are the images we built in the minds of the public and professionals.

It wasn't until just recently that the government just announced, all of a sudden, out of the blue, "Oh, by the way, we're going to deliver the services through the MSA." This is why I'm rather cynical about any reference to 70,000 people being consulted. I went to those public hearings—and a whole series of issues. People

wanted a 1-800 number. They didn't want to dance around the four agencies while people tried to assess them over the phone. They wanted to be able to go to your agency, but they didn't want to make four phone calls before they arrived at your doorstep for service. That's what the public said in this province, pure and simple.

Now, when you raise the issue of, is there a political agenda here, I want to propose a couple of issues for you and ask for your comments. I would have, if time had permitted me and I had shared my rotation with my colleague more and my number had come up when I sat through all of Bill 101—and you remember when that thing was unveiled and there was no reference to the cultural, religious, ethnic aspects of a whole infrastructure that has a history in this province for nursing homes and homes for the aged. I mean, the government literally had to be dragged to the table to get them to consider amendments that would acknowledge that these institutions exist. If you go back a step further and you look at our chronic care hospitals and what—frankly, the Catholic-based chronic care hospitals suffered the most in the last six years in the first hit that chronic care took in this province. It was the Catholic hospitals that got hurt the most by those government decisions.

Here we're seeing a trend, but Mr Marr tipped on it and it's the first time it's come up in the public hearings, and that is, is that the grand vision, the plan, the political agenda that eventually will move all our homes for the aged and retirement homes and all of those facilities under the MSA model now that we've disfranchised the mission statements, the ethnicity, the cultural diversity of these organizations?

Frankly, half my family is Ukrainian Catholic. I'm telling you, there is absolutely no way in the world that we can dismantle the kinds of deeply felt convictions about the need for service and how that service is rendered in this province. I see the MSAs and their structure as working against that, and eventually it'll percolate back up to the homes for the aged and the nursing homes and retirement homes around this province, and that may be the real political agenda.

Then there's that whole aspect of its implications for labour negotiations and how OPSEU and other organizations will absolutely refuse for an individual to say, "Quite frankly, I'd like my services provided by a Catholic agency," or, "I would like my services provided by someone who speaks Greek, please, because my mother only speaks Greek and she deserves the right to have her needs understood." But OPSEU's not necessarily convinced that that's appropriate in Ontario today. So your comments on those, please.

Mr Rochon: First of all, I'd like to say that the way I read this thing is that this thing started out with people objecting, "We can't get at that maze of agencies simply and it's confusing for us." We've all had that experience. How do you get a handle on this thing? But that was the problem. As a matter of fact, that piece of the problem, I might add, was the part that was managed by the government through home care. That was not well known and so people went to the agencies and said, "How do I

get at this?" and they said, "You go to home care or you go to your doctor," and so they kind of guided them around.

The part that screwed up, if you'll pardon that expression in this august hearing, was a governmental piece of it, the management of the governmental piece. I know everyone likes to take shots at the government, but that was the truth; so as a result of that, saying: "We've got a problem here in communication. We'll change the whole thing. We'll throw the baby out with the bathwater. We'll take the strengths and the weakness and we'll put them in a bundle and send them down the river."

I ask you, if you've got a well managed, cost-effective organization that's responsive to the needs of the community and is well respected, not only in Canada but in North America, for its excellence, why would you dismantle that in favour of an organization that's unknown, unproven and that has a heritage that is not particularly healthy in terms of management skills? I just find it very offensive to look at the destructive force this legislation puts into motion against people who have dedicated their lives, as many of the staff and the people who have worked in this organization have done, and the beneficiary of all of their work, with the support of their volunteers, has been the patient.

So the winner in this case somehow will be some kind of government agenda. The losers will be the taxpayer, because it's going to cost more, and the patient because the quality of services is going to decline. How does that make sense?

The Chair: I'm afraid with that question left there, we're going to have to move on because we still have one—

Mr Malkowski: Just on a point of clarification—

The Chair: I'm sorry, we have to move on. It's 25 to 6 and we're late and the Catholic Charities of the Archdiocese of Toronto have been here for some time. Perhaps you can work your question in at that time, Mr Malkowski. May I thank you all for coming on behalf of the Saint Elizabeth nurses' association.

HUMAN SERVICES ALLIANCE CATHOLIC CHARITIES OF THE ARCHDIOCESE OF TORONTO

The Chair: I invite the representatives from the Catholic Charities, who have been waiting patiently. I trust we've not kept you too late but I think you can sense the nature of the issues is such that we sometimes go over. Do you want to just take one second, just so people are leaving the room, and we'll get a quieter room for your presentation. If you would also just be good enough to introduce the members of your group.

Mr Brian Dunn: Thank you, Mr Chairman. We appreciate you staying over as well, and your committee. My name is Brian Dunn. I'm the president of Catholic Charities of the Archdiocese of Toronto. I've been a volunteer board member for five years and it's from that perspective that I'm speaking to you today. With me today, on my left, is Mrs Norma Barone, who is a volunteer board member and past president of the Cath-

olic Family Services of Toronto. To my right is Michael Fullan, the executive director of Catholic Charities.

Catholic Charities provides extensive funding for our member agencies throughout York, Durham and Peel regions, Simcoe county and Metro Toronto. Our goals are to provide leadership, to advocate on behalf of those in need of service and to ensure quality service available through our member agencies to all members of the community regardless—and I stress "regardless"—of religious affiliation.

We are here today as representatives of the Human Services Alliance. The Human Services Alliance has grown out of a small group of Catholic-value-based organizations which first met in the spring of 1993 to discuss common concerns and potential points of alliance in response to the rapid changes in the human services system. Today more than 40 organizations are members of the alliance, and they provide services such as housing, social services, health care and other components of the care system.

1740

The members of the alliance have a rich history and experience of reaching out to those in need: the disadvantaged and vulnerable; to those who are at risk of falling between the cracks of the existing system. Throughout our individual histories, we have continued to develop partnerships with each other in order to provide the best care possible to the community.

The Human Services Alliance has four main goals: to ensure a continuum of care for all individuals, to ensure consumer choice and local access to services, to preserve our members' service philosophy and values and to maintain our linkages within the community through our volunteer and staff commitment to its needs.

We believe that reforms to the human services system are necessary in order to better serve all members of our diverse community. The care system should be coordinated and responsive. It should be simplified so that access can be made through one phone call. However, we have concerns regarding Bill 173. Specifically, we believe Bill 173 will result in the disappearance of existing non-profit and charitable agencies, the reduction of volunteer support and donations and of individual choice.

We believe that Bill 173 as it is today will mean the end of the non-profit and charitable organizations we represent. Instead of building on the existing strengths of the human services system, in particular in terms of long-term care services, the government is proposing to tear it down and replace it with an MSA structure that will be extremely bureaucratic in nature.

With the disappearance of these agencies, community support, both in terms of donations and volunteer time, will disappear. From a historic perspective and a cultural perspective, people don't volunteer for government-based agencies. The members of the Human Services Alliance currently rely on the efforts of thousands of direct-service volunteers and over 500 volunteers at the board and committee level. These volunteers give their time because they appreciate the work we do, the agency does, and

because they particularly support a special service provided by one of our member agencies. They are attracted by our individual histories and service philosophies. Ongoing volunteer association with our agencies is supported by the quality of service provided.

If this community support was converted into financial compensation, it could conservatively be estimated at a value of \$10 million a year. We do not see this volunteer commitment and dedication continuing within a government-mandated structure. Volunteers donate their time because of the history and value structures of organizations, and if these lose their identity by being swept under a large government umbrella, a lot of people are going to say, "I'm not going to give my time or my money to serve the government." This would have a significant effect on those who rely on our agencies for services, as these invaluable assets would be removed from the system.

Disappearance of individual choice will be a direct consequence of the legislation. The ability to choose or seek a service will be seriously diminished with the introduction of a government-mandated structure for long-term care services. People will only be provided with the options the case worker decides to give them. If an individual is unhappy, an appeal mechanism does exist in the proposed legislation, but dollars and time would be wasted while the individual would not necessarily receive the care they wanted and needed.

We do believe that some of the provisions of Bill 173 could provide individuals with a choice, specifically those which establish a single access point for determining the availability of required services and the options which exist. But the delivery of care should continue to be the responsibility of these well established and high-quality service provider agencies which currently exist. For example, the Society of Sharing is a small, midtown Toronto agency. It's completely volunteer, providing friendly visiting to the lonely, the sick, elderly and mentally ill; over 100 volunteers. I suggest to you that that delivery of service is cost-effective. Of course there's St Elizabeth Visiting Nurses, with a history of over 86 years of service providing high-quality nursing care to the public.

We believe that the proposed long-term care service delivery model should be one of linkages and partnerships with existing agencies rather than the creation of one unwieldy bureaucratic structure. The system should be one of functional rather than structural integration. The legislation does speak of a four-year time frame to establish structural integration, but we do not believe that this consolidated model is the most appropriate goal. Further, we are concerned that no empirical data is available to substantiate the claim that structural integration will be cost-effective and responsive to individuals.

The Human Services Alliance is developing innovative examples of functional integration to service delivery. We have developed subgroups to look at care pathways for individuals with mental health needs, with palliative care needs and with needs that are specific to Alzheimer disease. All our member agencies are working together to build partnerships that will better serve the clients of our

communities in York, Durham, Peel, Simcoe and Metro Toronto.

Rather than creating a new structure, we are building on the strengths of our existing human service system, which includes our neighbourhood parish network, to provide the best and most flexible care possible based on the needs and choices of our clients. What we are missing is a single access point to services.

The Human Services Alliance suggests that the provincial government has a role in assisting individuals to access services by creating a single access point. As well, the province is responsible for developing and implementing guidelines, standards of service and provisions for protecting individual rights. As service providers in the care system, the Human Services Alliance partners are committed to working collectively to meet diverse human need. As partners, we can demonstrate coordination, flexibility, responsiveness and proof of cost-effective and respectful service delivery models.

We believe that the partnerships of the Human Services Alliance ensure continuous provision of high-quality care through existing non-profit and charitable agencies and will functionally integrate our long-term care services in the system. Voluntarism and financial support can remain as components that are invaluable to us and to the system. Better, more innovative and more flexible care can be provided by us in response to the needs and individual choices of our clients. All this can be achieved by the government playing a role in providing easier access to our services through a single access point rather than restructuring the entire system at enormous cost to the taxpayer and to the service consumer.

Attached to the submission is a list of the current members of the Human Services Alliance membership.

The Chair: Thanks. Mr McGuinty.

Mr Dalton McGuinty (Ottawa South): Thank you for your presentation. In fact, I want to take the opportunity to thank the two presenters before you, as well, for not sitting back and simply rendering unto Caesar that which is Caesar's but rather coming forward and making, I think, very powerful presentations.

I'm not an expert in this field and I think have acquired somewhat of an education on the basis of the presentations made so far today. But I think when you approach any particular legislation, what you've got to ask yourself is: "What is the policy that informs us? What is the thinking that has gone into this?"

To me, it's very clear. Bill 173 is based on the assumption that when it comes to delivering the kinds of services which form the subject matter of this legislation, bigger is better, and that if we are somehow able to deliver these services through a large, grey, monolithic institution which has no distinguishing features or characteristics, somehow this will be a better service to the end users or the consumers, to clients, the people who need the services.

I disagree with that heartily. I think that one of the real tragedies, if Bill 173 goes through, will be the loss that we'll experience in the voluntarism in the province which sustains so much of the social work that goes on, not

only in terms of these kinds of services but others as well, for which we simply cannot afford to pay. These volunteers are attracted by the texture of the various organizations, religious or otherwise, that have come to deliver these kinds of services in the province.

In terms of a question, the answer is obvious but I want to put it to you anyway. Notwithstanding what I've said in my criticism, the act's got the right buzzwords. It's got the right catchphrases that you want to put into legislation in 1994 in Ontario. If you look at the purposes, it says we're going "to ensure that a wide range of community services are available," we're going "to recognize the importance of a person's needs and preferences," we're going "to promote efficient management"—just reading some of the wording from the objectives.

Then we go to the Bill of Rights and it talks about promoting autonomy or recognizing "individuality...that respects cultural, ethnic, spiritual, linguistic and regional differences." Then it goes on to say the act "shall be interpreted so as to advance the objective that the rights set out..."

1750

Is this act, in your mind, advancing those objectives? Is it giving autonomy? Is it giving freedom of choice? Is it respecting religious and cultural differences?

Mr Dunn: We don't think so. From the point of view, again going back to just the voluntarism aspect, I'm sure all of you have volunteered at one time or another. Why did you do it? Think about why you volunteered. Basically it was because it was probably a local agency. You appreciated the work that agency did. Maybe it had a special service that you appreciated was provided to your mother or your grandmother, or you personally identified with the mission and the service philosophy. We don't think that's necessarily going to be the case here.

You have to remember, I think, that charitable agencies, most of them, started because they were based on the communities, on either a faith, a linguistic or a cultural basis for it. That's not the situation here. We're just going to start MSAs on one day. There's no historical basis, or cultural basis, for that matter, to volunteer for government-type agencies. It's naïve in the minimum. I think it's ludicrous in the extreme.

Mr McGuinty: Just a follow-up, Mr Chair: One point on that is that we as politicians ourselves recognize the importance of different institutions and traditions and cultures. When I run in my riding, I don't run as somebody who wants to be in a government; I run as a Liberal. When I raise money, I try to raise money as a Liberal, and so does everybody else around this table for their respective parties. We run on behalf of a party because it has a history attached to it, and this act doesn't recognize that.

Interjections.

The Chair: Order.

Mr McGuinty: This act goes against that fundamental truth which recognizes that people quite naturally have attachment to history and tradition and distinguishing characteristics.

Mr Michael Fullan: If I could just add one point

about our volunteer piece of this, Brian had talked earlier about the \$10-million value added if we were to translate the volunteer hours into dollars. What is not included here, and we haven't done a very good job of selling ourselves, is the tremendous volunteer capacity at the parish level. We don't hear that. That goes virtually unrecognized for the most part, quietly going about, and that's been continuing for many, many years. As I say, we haven't sold that very well at all, but it's a very active part of who we are and of our agencies and our service to the community. That would literally be thousands and thousands more hours and millions of dollars if we were to translate that.

Mr Tony Martin (Sault Ste Marie): I found the three presentations this afternoon rather interesting. You make some very compelling arguments but as well present to me some rather disturbing perspectives. I'm a Roman Catholic as well and, as one letter to the editor stated a couple of weeks ago, a self-proclaimed Roman Catholic, and, you know, certainly have been the beneficiary of and have contributed in many significant ways to some very interesting things in my community by way of service and that.

However, I don't share with you some of the cynicism that you brought today re the ability of government to deliver programs. I didn't know how many government workers lived in my community until the social contract last year. I recognize that many neighbours and friends worked for government, very hard-working, committed, dedicated individuals who do their job well, who go beyond the call of duty, on many occasions come home late, go to work early and contribute in significant ways to the fabric of this province and work very hard. For me to sit here and listen to folks be cynical about that I guess disturbs me because it speaks to a more fundamental problem re what we face as we move towards the end of this millennium and into the next century, and my four children.

The other thing that concerns me is the sense that somehow because we're Catholic we do it better or that we have a corner on the market re the issue of volunteering and raising money and all that kind of thing. I have to tell you that I used to think that. I used to live in Ireland where we thought a lot of different, very sad things about people who weren't Catholics. I've come to learn differently in my experience as a person who lives in Ontario, a multicultural, very diverse province that leads in the world in recognizing the richness of the various people who live in our communities and what they can contribute. To suggest for a minute, it seems to me, that I will only volunteer or raise money or give money if it's to some Catholic organization or spiritually rooted organization or some organization that only has local connections—I look at this province and I look at the thousands of people who participate with government in the whole area of trying to save the environment for a myriad of different reasons, who work within my community in the jails, and in the northern treatment centre for a myriad of reasons: some of them Catholic; some of them of no faith connection whatsoever. To suggest that there's some devious, political agenda on the table here

as well disturbs me personally, if not as a member of this government at least. Our agenda is simply to make sure that long-term care is delivered in this province in a way that is cost-effective and available to people from one end of the province to the other. The choice question is really one of a choice of having that care delivered.

There was reference made earlier by Mr Marr to an exercise that happened in Sault Ste Marie over the last couple of years when the two hospitals came together. That wasn't without some tremendous struggle and effort and—continued today and into next year—pain as we laid off very valuable employees in both those institutions so that we might take advantage of the efficiencies that could come with that. We still continue to deliver health care in Sault Ste Marie in, I think, a quality atmosphere and in a way that all of us can be proud of.

I ask you to maybe comment on some of those questions that I struggle with now as a member of this committee as I try to deal with this legislation.

Mr Dunn: If you've been in any way involved in trying to secure volunteers, you'll know it's a difficult task. With Catholic Charities we have 29 various agencies and, with the Human Services Alliance, we're up to over 40. We don't ask their religious affiliation when they come through the door to volunteer for one of our agencies. We don't do it. It's the same as when we deliver service; we don't ask what religious affiliation you are when we deliver service.

So we're not suggesting to you that this is just a Catholic thing; that the Catholics aren't going to volunteer. I suggest to you that anyone with the VON who has been volunteering with them might turn around and say, "I think maybe I'm just going to volunteer for the local hockey association." There's no history, I say to you, of people volunteering for a government-based agency that starts on day one looking for volunteers. I just don't think that's going to be the case. I think it's naïve of us to think that's going to be the case.

Ms Carter: It is still community-based, like the hospital—

Interjections.

The Chair: Excuse me.

Mr Dunn: All right. Let me continue with that—

Interjections.

The Chair: Order, please.

Mr Dunn: I'm not suggesting everybody, as soon as the legislation comes in, is not going to recognize a responsibility to volunteer, but it's the degree of support that you're going to get. When people start to realize that they're supporting a government-based agency, they are going to think twice about continuing their voluntarism. That's our submission.

We may be completely wrong, but you're taking a chance on losing, as we suggest, possibly upwards of \$10 million worth of volunteer time.

Mr O'Connor: Are you planning on—

The Chair: Excuse me, please. One last supplementary for Mr Malkowski and then we have to conclude.

Mr Malkowski: Are you people aware of the Progressive Conservative philosophy on long-term care, and would you support their strategy to shift from community-based to institutional-based models in long-term care? Would you like to comment on that?

Mr Jackson: Point of order, Mr Chair: I'm unfamiliar with Mr Wilson and I having ever commented on that in this hearing or in the previous hearings on 101. In fairness, Mr Malkowski shouldn't play with words in such a fashion. It's quite unfair.

Mr Malkowski: To be fair, in response—you said Bill 101. You've talked about institutional care before. I want to hear their comments on your party's platform, in point of fact.

Mr Jim Wilson: That isn't our party platform.

Mr Jackson: If Mr Malkowski wants to ask me a question about my party's position, fine. But that's a completely unfair question to these people unless they're all Conservatives and they're aware of our party's policy. This line of questioning's only going to make them Conservative.

The Chair: Order, please. Order. I think it being 6 of the clock and since memories of policies may be a bit dim, we'll conclude at this time. I want to thank you for coming before the committee and for your presentations.

Mr Dunn: Thank you, Mr Chairman.

The Chair: The committee will resume tomorrow morning at 10 o'clock. It stands adjourned.

The committee adjourned at 1800.

CONTENTS

Monday 15 August 1994

Long-Term Care Act, 1994, Bill 173, <i>Mrs Grier</i> / <i>Loi de 1994 sur les soins de longue durée</i>, projet de loi 173, <i>M^{me} Grier</i>	S-1605
Ministry of Health	S-1605
Hon Ruth Grier, minister	
Paul Wessinger, parliamentary assistant to the minister	
Geoff Quirt, acting executive director, long-term care division	
Gail Czukar, legal counsel, long-term care legislation	
Registered Nurses' Association of Ontario	M-1623
Kathleen MacMillan, president	
Johanne Mousseau, member	
Margaret Watson, executive director	
Jacqueline Choinière, nursing practice and policy coordinator	
Ontario Medical Association	M-1629
Dr Michael Gordon, chair, advisory group on long-term care	
Dr Barbara Clive, member, advisory group on long-term care	
York Region Home Care Program	M-1634
Carol Dockrell, director	
Brenda Andrachuk, program manager	
Association of Treatment Centres of Ontario	M-1638
Joanne Renahan, chair, long-term care committee	
Diana Thomson, member, long-term care committee	
Catholic Health Association of Ontario	M-1643
Ron Marr, president	
Sister Bonnie MacLellan, member, long-term care task force	
Sister Alice McEvoy, board member and chair, long-term care task force	
Saint Elizabeth Visiting Nurses' Association of Ontario	M-1648
Shirlee Sharkey, president and chief executive officer	
Joel Rochon, board chair	
Human Services Alliance; Catholic Charities of the Archdiocese of Toronto	M-1653
Brian Dunn, president, Catholic Charities	
Michael Fullan, executive director, Catholic Charities	

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- *Chair / Président:** Beer, Charles (York-Mackenzie L)
Vice-Chair / Vice-Président: Eddy, Ron (Brant-Haldimand L)
***Carter, Jenny** (Peterborough ND)
Cunningham, Dianne (London North/-Nord PC)
Hope, Randy R. (Chatham-Kent ND)
***Martin, Tony** (Sault Ste Marie ND)
***McGuinty, Dalton** (Ottawa South/-Sud L)
***O'Connor, Larry** (Durham-York ND)
***O'Neill, Yvonne** (Ottawa-Rideau L)
Owens, Stephen (Scarborough Centre ND)
***Rizzo, Tony** (Oakwood ND)
***Wilson, Jim** (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Jackson Cameron (Burlington South/-Sud PC) for Mrs Cunningham
Malkowski, Gary (York East/-Est ND) for Mr Hope
Sullivan, Barbara (Halton Centre L) for Mr Eddy
Wessinger, Paul (Simcoe Centre ND) for Mr Owens

Clerk / Greffier: Arnott, Doug

Staff / Personnel:

Boucher, Joanne, research officer, Legislative Research Service
Gardner, Dr Bob, assistant director, Legislative Research Service



S-59

S-59

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Tuesday 16 August 1994

Journal des débats (Hansard)

Mardi 16 août 1994

Standing committee on
social development

Comité permanent des
affaires sociales

Long-Term Care Act, 1994

Loi de 1994 sur les soins
de longue durée



Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Tuesday 16 August 1994

Mardi 16 août 1994

The committee met at 1010 in room 151.

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

ONTARIO HOME HEALTH CARE
PROVIDERS' ASSOCIATION

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. The standing committee on social development today continues hearings on Bill 173, An Act respecting Long-Term Care.

I invite our first witnesses to come forward, the representatives from the Ontario Home Health Care Providers' Association. Welcome. If you would be good enough to introduce yourselves for the members of the committee and for Hansard, please go ahead with your submission. We have received a copy.

Mr Steve Haas: I'd like to thank the committee for the opportunity of making a presentation on Bill 173, An Act respecting Long-Term Care. My name is Steve Haas. I'm the president of the Ontario Home Health Care Providers' Association and also a vice-president of Paramed Health Services. With me today are David Gooch, the past president of the association and the owner of Community Homemakers in Mississauga; and Allayne Evans, who is a vice-president of Bradson Home Health in Ottawa and the second vice-president of the association.

Before we begin discussing the bill, I'd like to tell you about our organization and who we represent. The Ontario Home Health Care Providers' Association is the organization that represents commercial home care agencies in Ontario. Working through 115 offices across Ontario, our member agencies provide nine million hours of government-funded home care annually to seniors, disabled persons and children. Collectively we employ over 20,000 nurses, home support workers, occupational and speech therapists, physiotherapists and administrative staff. Approximately 40% to 45% of publicly funded homemaking services in Ontario are provided by OHHCPA members.

Our organization was founded in 1986 and has two primary purposes: to encourage excellence in the provision of home health care services and to represent member agencies regarding public policy issues affecting home health care.

It's our intention during this presentation to compare the elements of the legislation with the solutions that we,

as experienced providers, propose for the problems in home care.

There is no doubt that changes are needed. Too often, home care can seem fragmented and uncoordinated to those who need care. We support change. However, Bill 173 doesn't reform the current system; it destroys it.

We believe that the imposition of multiservice agencies will be a step backwards, because instead of saving money it will be more costly than the current system. It won't be more responsive to consumer needs but rather less responsive because it is a monopoly.

We wish specifically to address the impact this legislation will have on people who need home care and workers in both the private and non-profit sectors and on businesses in Ontario.

Initially, it was this government's policy to restrict commercial agencies to providing 10% or less of all home care services. Effectively, this policy would have driven almost all our member agencies out of business. When the legislation was introduced, the 10% restriction was dropped and in its place was a 20% limitation on all providers, non-profit and private sector. We predict this will have a devastating effect on those agencies. Whether the restriction is 10% or 20% is not particularly relevant. Such a restriction will cripple an agency's ability to retain the critical mass necessary to survive.

I don't wish to dwell on the impact this legislation will have on businesses, but I would like to make a couple of observations.

The impact on businesses founded and developed by Ontario entrepreneurs will be disastrous. As a result of this bill, they stand to lose those businesses and thousands of our workers in Ontario will lose their jobs, and the international business community will have another lesson about the risks faced by private companies that do business in Ontario.

Interestingly, the threat of collapse also faces most of the current non-profit and volunteer agencies as well. Since the legislation mandates that the MSA manage the system and provide the services, current agencies will be swallowed up by the MSA. Gone too will be volunteer workers in the system. We expect that once the entire system is seen to be managed and controlled by government, volunteers won't donate their time.

Our concern today, however, is to convey not only the impact on our workers and businesses but equally the damaging impact of this legislation on home care consumers.

The Minister of Health states that the MSAs will bring

one-stop shopping to the home care system. It will be one-stop shopping, because under this bill there will be only one place to shop. What it will mean to a person needing home care is that if the MSA does not meet his or her needs, whether those needs are clinical, ethnic, spiritual or linguistic, there is nowhere else to go. The consumer will lose all choice.

The great weakness of this legislation is that the MSA will be both the system administrator and a provider. It's an absolute monopoly without any motivation to serve the needs or wishes of consumers, who can't go anywhere else.

In an MSA, clients who are unhappy would have to report that dissatisfaction to the very same agency that decides the availability of services. Despite the government's plans for an appeal process, it isn't very difficult to imagine the fear a vulnerable person might have about daring to complain or speak out.

In the current system, clients who speak out can have their services provided by another agency. This is one of the positive features created by competition, something that will be totally eliminated by Bill 173.

Models like the proposed MSA have been tried and abandoned in other countries, notably Great Britain and Sweden. Other provinces, such as Manitoba, which have moved the private sector out of home health care, are now reversing their policies and want to reintroduce some form of competition in the provision of home care.

Therefore it is our recommendation that at the very least Bill 173 be amended by deleting section 13 in its entirety.

Dave Gooch is going to comment on some of the solutions we see as more effective than the proposed MSAs.

Mr David Gooch: I'm the owner of Community Homemakers in Mississauga and Toronto. My agency will be out of business when this bill takes effect. The employees will be laid off and the experience and expertise we have built up since 1975 will be lost to future home care clients.

There are two specific areas I wish to address in my remarks: the need for a coordinated information system and our opposition to the provincial government's attempt to manage the local day-to-day operations of the home care system.

Section 12 of the legislation defines which services the MSAs will provide, subject to funding restrictions and possibly waiting lists. The list is extensive but it is also restrictive. Subsection 12(2) prevents local authorities from providing additional service without the approval of the Minister of Health.

Second, as was mentioned previously, section 13 restricts local authorities from acquiring home care services from outside agencies.

These are two examples of how the provincial government is attempting to manage the entire home care system from downtown Toronto. We believe this bill ignores the legitimate autonomy that local administrators must have to meet the individual needs of local clients.

Home care administrators in many communities have

challenged and in some cases are defying the government attempt to limit the private sector. Local authorities in Ottawa-Carleton, Hastings and Prince Edward, the Kingston area, Haliburton, Kawartha and many others have publicly rejected the government's non-profit preference policy. They have done so because they don't believe that a restrictive, non-competitive policy benefits their communities.

Our members have reported that there is considerable discomfort among local authorities across Ontario about this legislation, and we share their concerns. The OHHCPA believes that government should provide as much freedom to local authorities as possible. The Ministry of Health should develop overall home care policies, define core services, determine the level of financial resources that can be made available, then allocate these moneys to local communities so they can determine the priorities for home care.

The government can also play a central role in ensuring badly needed coordination for the entire system. As an agency operator, I am fully aware of the problems created by the lack of coordination among service providers. I believe the cause to be the absence of proper information management systems. An information management system would ensure that consumers receive appropriate and continuous care, from acute to chronic to long-term care. Instead of coordinating services, Bill 173 creates a total monopoly far beyond what is needed.

It is our view that had the government originally approached this entire issue from the perspective of filling the information and management needs of the current system, meaningful improvements would already be coming on stream and this legislation would be unnecessary. It is frustrating to watch government plan large-scale restructuring when comparatively minor changes would have succeeded better.

Finally, I want to state our belief that the cost of MSAs will be borne by future clients of home care in Ontario. The increased costs of an unneeded bureaucracy will come from the limited moneys available for home care services. Clients will in the end have fewer services.

Allayne Evans will elaborate on how consumers and workers will be adversely affected.

1020

Ms Allayne Evans: Good morning. The 80%-20% restriction on contracting out will mean that many people will be out of jobs, trying to find a job in a health care system that has severely been constrained in the last few years. Their experience and their training in the delivery of home care will be lost.

The majority of people who work with me are women. Many of them are new Canadians and they're concerned about their futures. This legislation makes no commitment to them for any future employment whatsoever. It's not just commercial employees who will be vulnerable to lost jobs. Workers in the non-profit agencies will have the same fate.

Throughout these hearings, I hope that some of the front-line workers will come to this committee and explain what they're going through, but many of them

think that if they make public statements, it will hurt their chances of finding employment in the MSA of the future.

I don't run a large company; it's a local business with local workers. Many of the home care agencies that make up OHHCPA are owned and operated by women. The services we provide are meeting the needs of consumers. Quality is not an issue and never has been. If we don't maintain a high quality of service, we lose contracts to other agencies. Competition is the driving force ensuring quality.

One of the reasons the commercial sector has enjoyed success in the home care field is because of our innovative ideas. We've moved into other areas where other agencies weren't providing care. We began providing care 24 hours a day, seven days a week, holidays included. We did this to provide care to clients to meet their needs and not the needs of a bureaucracy.

Commercial agencies have exactly the same funding from the government as the non-profit sector. Studies have shown that we pay our workers the same as those in the non-profit sector. There has never been a concern about the quality of care delivered by either sector. To the government, it should make no difference who is providing the service. We've heard the Minister of Health say that funds should go into care and not profit, but there's nothing—no research, no studies—that shows that non-profit agencies deliver better care than commercial agencies. The government pays the same rate for service regardless of who provides it.

For me, running a home care agency isn't about profit, it's about people. Our business is care giving. We've succeeded because we provide services to people in a caring way. Our clients rely on their care givers. A positive, supporting relationship between a client and a care giver unquestionably contributes to their wellbeing. These are vulnerable people sometimes and they look forward to the consistency in their care provider. We know from years of experience that clients don't like arbitrary changes, and they never hesitate to inform us of what they don't like. I don't believe that an MSA will provide the responsive, flexible service that consumers need.

Under Bill 173, any degree of consumer choice, local autonomy and creative response to client needs will be lost because consumers won't risk complaining or asking for changes for fear of losing what they already have. They will know that the same people they complain to not only provide their care but decide whether they get care at all.

In a letter to the minister, the board of health in Kingston explained why it opposed limitations on commercial providers: "The board is concerned that it is already starting to see the not-for-profit providers start to attach restrictive provisions to their services. This results from the creation of near monopolies among providers. Such a restriction in service is in addition to the restriction in quality which results from the disruption of continuity of care."

We could haven't said it better ourselves, or with as much authority.

This legislation goes far beyond the needs of the consumer and will, in some areas of the province, reduce the level and quality of service provided to the people of Ontario.

Mr Haas: I think we've made it clear that the Ontario Home Health Care Providers' Association opposes this legislation and the implementation of MSAs. We are, however, not opposed to reforming the home care system. We have recommendations that would bring about reform without creating yet another massive bureaucracy.

The government should determine what services it can afford to provide and then fund those services in an equitable and consistent fashion across the province.

Local communities should ensure that services are provided as efficiently and effectively as possible through managed competition among all providers.

Consumers should have much more choice in the services they receive as individuals rather than having to fit into specific programs.

The development of a client-focused information system which coordinates community and facility care must be a priority.

Our last recommendation: The government must give local communities responsibility to allocate resources at the local level in response to local needs. The Ministry of Health must stop trying to manage day-to-day operations of home care.

We've offered some positive suggestions on ways the home care system can be improved to meet the needs of consumers while maintaining the essential qualities of the current system, such as competition, consumer choice and local autonomy.

It's our sincere belief that Bill 173, in its current form, will strip positive qualities found in the current system. The ultimate victims of the proposed system will be home care consumers, who will have far fewer services and less choice.

Thank you for listening, and we're happy to answer any questions.

Mr Gary Malkowski (York East): Thank you for your presentation. You have stated that you would lose great numbers of employees because of the expansion of long-term care. We feel these will be picked up, anyway, by the MSAs if people are displaced. But we don't think it's the case that you would lose a whole lot, because it's my understanding that a lot of your funding comes from private dollars and I don't think the changes with long-term care really affect you at all. Could you comment on that?

Mr Haas: My response would be that the system as it exists today has our companies providing a small amount of private services in addition to a significant amount of government services. We won't have the critical mass, as individual agencies, to survive, any more than the non-profit agencies will have the critical mass necessary to survive the limitation on contracting out.

Mrs Barbara Sullivan (Halton Centre): I appreciate this presentation. I'm astonished, frankly, at the last question from Mr Malkowski, because I think it's clear that he doesn't understand, first of all, the position now

of the commercial sector in home care provision, which is close to half of all home care provided in the province; nor the devastating impact of the removal of government-funded contracts, I suppose, for home care. In fact you will be put out of business, and there is no compensation contemplated for the loss of your capital, for your operation, for any physical facilities you own and so on, nor for the time and energy that's been put into the operation of your businesses. There is no indication in any publication, in any study, that the services your members have provided are of any lesser quality or any less evaluated than the non-profit or public sector services that are provided, so I'm just astonished at that.

I'm quite interested in the last points. You talk about a funding basket, a basket of services that the government should determine should be made available. I think the government has done that in this bill in the definition sections of what are community services etc, professional services. What is not included in this bill is a guarantee that those services will be provided, because of the funding.

1030

Once again we've talked about raised expectations. I'd like to know what action you see your members taking with respect to compensation for your lost investments and how many of your members you think will be completely out of business, therefore leaving people who would not be using the public system for home care at risk or without services.

Mr Haas: I could begin the answer by saying that with regard to the compensation, we didn't mention it and didn't feel we had to because it doesn't specifically relate to Bill 173 at this point, but we did initiate a legal action against the government with regard to compensation and we will continue that.

Mr Gooch: With respect to the impact on our industry, there is an error on the part of Mr Malkowski in his understanding of the private sector and of the nature of our businesses. In most cases, and in the case of my agency over the past 20 years, our growth has been through our involvement and our cooperation with local home care programs in Peel and Toronto to the point that 70% to 80% of what we do is to provide services to those programs, and that is fairly typical of private sector agencies across the province.

It's not hard to imagine that any agency, whether it be us or whether it be Red Cross or Saint Elizabeth, that loses 70% to 80% of what it does would be at serious risk. It's hard to imagine that we would be able to continue to provide services. We don't really have an estimate, but it certainly represents the majority of private sector agencies across the province that would find themselves in the same position.

Mrs Sullivan: Have your discussions with the government led you to any conclusions with respect to the labour adjustment policies that might be put into place so that employees who are currently employed by what will now be defunct companies will in fact find work in the MSAs?

Mr Gooch: We've stood with the non-profit sector,

with the Red Cross, Saint Elizabeth and VON, in meetings with the minister's staff in asking for guarantees for the protection of jobs for our workers. We've also negotiated, through the development of HSTAP, the Health Sector Training and Adjustment Panel, for the same type of protection for our workers, but we have not been able to get that type of guarantee. Obviously, as you see in the legislation, there is no protection for our workers who find themselves in an open, competitive market for jobs once the restructuring takes place.

Mrs Sullivan: Is it your sense that there is protection, or at least a promise of protection, for workers who are union members?

Mr Gooch: We have faced in our discussions at HSTAP and in other places where unionized workers have requested protection for their workers to be guaranteed in the community sector, which places our workers in the back seat looking for jobs in that sector. Yes, we've heard at all levels of government that same sort of promise.

Mr Jim Wilson (Simcoe West): Thank you for the presentation. It's kind of déjà vu all over again. We went through much of this with Bill 101 with the government trying to drive you out of business. It's just that this time—and everyone in the room should know this, and particularly the Toronto Star should know this, because in today's Star there's a rather God-awful article, by Bill Walker, that didn't reflect yesterday at all.

Mr Larry O'Connor (Durham-York): The word is "negative."

Mr Jim Wilson: I'll have a little chat with Bill because it certainly didn't reflect what was heard here yesterday. None the less, the government this time has also decided to put the Red Cross and VON and the non-profits out of business, or at least out of the way they're currently doing business, with their volunteer boards. Why? I don't know, other than, I suspect—Mr Quirt, for example, when he spoke to the committee yesterday, talked about the 70,000 people they consulted, and the government says it heard through that consultation that people wanted one-stop shopping. I went to one of those meetings and people simply wanted one phone number to contact in their local community and they wanted a knowledgeable person at the other end of the phone. But then Mr Quirt went on to tell us that those 70,000 people, the majority of them, also wanted the MSAs to deliver the services.

That's very clearly, though, a government spin on what they heard, because I don't recall anyone in the many, many meetings I went to, particularly in my own community, assuming that the government was going to take over the delivery of services through MSAs, and MSAs are government. They're government-appointed, much like large parts of our DHCs, and the government in a sense is setting up a monopoly on this system.

You talked quite correctly about competition and the evolution of your sector, that you were there to respond to the off hours, were there to respond in areas where other agencies' services at the time weren't available. You didn't grow up through any master plan of government; in fact I think you grew up, through three different

governments now, because there was a demand there from consumers, and nothing else.

The consumers we've spoken to, which would number in the thousands over the past three years, all still expect that the Red Cross and Dynacare and private sector service providers are going to continue to provide those services. They don't know what this legislation's about.

You mentioned you hope your employees come forward. I hope employees come forward too, because we know this government's capable of changing its mind. When 4,000 employees of the auto insurance sector appeared at Queen's Park, the government soon backed down, especially when the secretaries and the people who aren't corporate executives appeared at Queen's Park and said: "Get out of my life, government. You're ruining it and now you're going to end my job," and told this government to take a hike.

I would tell your employees, and I will do everything I can to ensure that they understand the implications of this bill. There is no job security. There are some rumours that perhaps unionized employees will have some job security, but I doubt it. I think the government has a moral obligation to provide job security to everyone.

I want to leave you with the thought that, very clearly, the 80-20 rule will go the way of the government's Bill 40 job-killing labour laws if my party forms the government in the next 12 months. There is no hesitation on our part whatsoever. The problem is, and I want you to comment on this, that the 10% rule was a policy statement by the government, something concocted in cabinet. This darned legislation has the 20% rule actually put in the legislation, which means any government, the next government—certainly all indications are right now that it won't be the NDP government in the next 12 months—has to go back to Parliament, which becomes a lengthy process of undoing all this social engineering the government has done. But I assure you we will go through that process and we will undo what they've done.

I also want to make sure people are aware that when you get into the regulatory section, it's not just an 80-20 rule. If you look at the regulatory section, paragraphs 56(1)37 and 38, the government can also prescribe rules in addition to those contained in section 13, section 13 being the 80-20 rule, "respecting purchases of services by approved agencies from other service providers;" and 38, "governing the relationship and the contracts between an approved agency and any person from whom it purchases community services."

Just one last thing: As you know, where this leads—and the public should understand this and the non-profits should understand this. I brought to the attention of the House before it adjourned the case of a new non-profit home care agency that was told by the government that it could not—for example, it was contracting services with a private firm for intake services and assessment. It eventually boiled down to the fact that because that was a percentage of approved budget—they had hit their 10% mark—they therefore couldn't buy pens any more from Grand and Toy, they couldn't go out and buy bandages from a medical supply company. They couldn't do

anything with the private sector because they had hit their 10% of approved budget. Now that arbitrary figure has been moved to 20%, but it basically put them right out of business just overnight, and we couldn't get the government to budge on it whatsoever. I think the public should understand that when it says 20% of approved budget, you're screwed in a variety of ways. You're out of business.

Mr O'Connor: Mr Chair, I hope you're going to allow an opportunity for my colleague to speak.

Mr Jim Wilson: I just want you to comment on that, because it's not just the draconian section of section 13 where it says 80-20, but also should the government, as in the case of this one new non-profit—it took a dislike to it and used the regulatory authority to just put it out of business, and it was extremely unfair. I'll give you an opportunity to comment on that.

Mr Haas: I would want to add to what you said about the consultation process. The only written report we ever saw on the consultation process was from the Peterborough area office—5,200 people responded in their area out of 75,000—it reported that the conclusion on what the then service coordination agency should do was purchase service from profit and non-profit providers to enhance quality assurance and competitive pricing.

Ms Evans: I'd like to respond to the 80-20 comment: 80-20 or 90-10, they're arbitrary figures. Where do they come from? What do they represent? What they mean to us is that we will be out of business and our employees will be out of jobs, and I think that's the best answer I can give you to the 80-20.

Mr Jim Wilson: Just as a point of information: We did ask the government yesterday where it came up with the 20% figure, and it's unable to show us any documentation whatsoever.

1040

Ms Jenny Carter (Peterborough): I must say I don't recognize the bill that I see when I listen to some presentations, because what we have here is a consumer-oriented bill. It's set up to give the best possible service to the consumer. It's not a bureaucracy, because it's based on the local community. The people who run this are going to be locally elected boards—

Mrs Sullivan: Elected?

Mrs Yvonne O'Neill (Ottawa-Rideau): Appointed is the word.

Ms Carter: —very similar to some already there in the field, and as I say, we're definitely not setting up a bureaucracy.

Now, I'm concerned about this question of jobs and pay. I must say that the Tories are certainly not people who ever protected the rights of immigrant home-makers—

Mr Jim Wilson: In 42 years we did a heck of a good job of it. It's a much better province.

Ms Carter: —or that they did a great deal for pay equity. But the question I'd like to ask you is, commercial providers, as you say in your presentation, are paid the same rate as not-for-profit providers for the services

they give. Now, although you have said that your workers are just as well off and that your services are of equal quality, the profit must come from somewhere. I'm just wondering where that profit margin is actually found. Is it lower wage rates, or does it come off the quality of care?

Ms Evans: We pay the same wages as the not-for-profit sector. If we didn't, our employees would go there. It's easy to do; they're located everywhere. We have to be competitive with wages with our employees, and we are.

The issue of quality: That came from Ruth Grier herself in June 1993, when she stated categorically that quality was not an issue in this 90-10, the original. That's not just coming from us; that's coming from the minister herself.

The issue of an MSA not being a bureaucracy? I don't know how to argue that to you other than what we've done. I see that it will be a huge bureaucracy, with what's called the basket of services being dictated by Queen's Park. It may be run through the district health council and the long-term care area offices, but it's Queen's Park that is saying what will go into this basket of services. It's not my local district health council deciding, and it's not my local home support agencies—non-profits; we talk all the time—who will decide what is needed in their communities. It's Queen's Park that will decide.

Ms Carter: There's going to be an envelope—

The Chair: I'm sorry, we're going to have to call that a close. We're over the time. I know we could go on for a while, but we do have other presenters this morning. Thank you very much for coming.

I call the Ontario Coalition of Senior Citizens' Organizations.

Mrs Sullivan: On a point of order, Mr Chairman: While the next group is coming forward, I wonder if the parliamentary assistant could clarify. Ms Carter has indicated to the public hearing that the boards of MSAs will be locally elected. That's not found anywhere in the legislation, nor has it been described in those terms by the minister nor by anyone else, as far as I know. In fact the creation of the boards is something of a mystic process. I wonder if the PA could describe how these boards will in fact be set up.

The Chair: Very quickly, please.

Mr Paul Wessinger (Simcoe Centre): I think I will ask legal counsel to indicate, refer to the sections of the act. That probably is the best way to clarify it.

Ms Gail Czukar: The definition of "agency" in the bill is where you find that. The MSA is an agency that's been designated by the minister. It first has to be an approved agency. The definition of an "agency" is a non-profit corporation under the Corporations Act which is an independent corporation that is formed by local community people and which develops its own constitution and bylaws, which can be approved by the minister and which will be filed with the minister and reviewed and approved.

We also have the power in the bill to prescribe particu-

lar kinds of bylaws, if necessary, in order to ensure that it's an open membership to allow an open membership to elect the boards and to ensure consumer representation on the boards. That's where the locally elected provisions are found: section 2 and sections—

The Chair: I'm really going to have to intervene here. I know we can get into a discussion of some of these things but we've got—

Mr Jim Wilson: Except, Mr Chairman, that can't go unamended.

The Chair: Okay, very quickly, please.

Mr Jim Wilson: It doesn't say "elected." What they're telling us is that in the regulation, using the regulative authority here, that's what they're going to do. Could we have that in writing, exactly what you—in fact, give us the regulation, if you've already got it written.

Mrs Sullivan: And is it elected from within membership?

Interjection.

The Chair: Okay, can we—

Mr Jim Wilson: Because so far—

Mrs Sullivan: Who qualifies to be a member?

Mr Jim Wilson: That's unfair. I mean, obviously they told you people it's going to be elected. I want that as a public—

The Chair: Order.

Mr Malkowski: Maybe you finally learned something over there. So much for your homework.

Mr Jim Wilson: How can we do homework when we don't even know what the regulations are?

The Chair: I think if we can come back to that, the question is on the table, but we do have witnesses who are here this morning. I want to make sure that we hear from them.

ONTARIO COALITION OF SENIOR CITIZENS' ORGANIZATIONS

The Chair: Our next witnesses are here, the Ontario Coalition of Senior Citizens' Organizations. Welcome to the committee. If you'd be good enough to introduce yourselves, we do have a copy of your submission, if you would please go ahead.

Mr Dan McNeil: Good morning, Mr Chairman and members of the committee. My name is Dan McNeil, co-chair of the Ontario coalition. On my left is Bea Levis, our other co-chair, and on my far left is our director of operations for the coalition, Morris Jesion.

The Ontario Coalition of Senior Citizens' Organizations, OCSCO, would like to thank the standing committee on social development for the opportunity to present our views on Bill 173, An Act respecting Long-Term Care.

First, we would like to acquaint you with our organization. The Ontario Coalition of Senior Citizens' Organizations is a seniors' organization dedicated to providing an opportunity for seniors to become involved and participate in society. OCSCO acts as a forum to bring representative groups of seniors together to share information, raise issues of common concern and engage

in group activities related to those concerns. For instance, our organization has dedicated much of its time and effort into long-term care reform. OCSCO, in conjunction with the long-term care alliance, has worked to give seniors a voice in the long-term care reform debate.

The objectives of OCSCO are to represent and speak on behalf of its member organizations on issues identified by the coalition; to provide a forum for senior citizens' organizations and other relevant bodies; to share information on matters of common concern; to educate and research on issues identified by the membership; to provide the government and community with a broad, organized channel of communication to the senior citizen community; and to consult with government and/or other groups.

OCSCO's membership consists of 66 organizations, representing more than 500,000 seniors across Ontario. On matters affecting the quality of life of the senior citizen community, OCSCO unites both large and small groups from community, union, ethnocultural groups, natives and veterans' organizations. OCSCO member organizations include the Older Women's Network, the Federation of Italian Seniors, the United Steelworkers of America Retirees, Ontario Public Service Employees Union, Toronto Mayor's Committee on Aging, the Older Adult Centres Association of Ontario, Canadian Pensioners Concerned and the Federation of Francophones of Ontario.

Ontario's long-term programs have been undergoing reform for many years. Health and social services in Ontario have been characterized by increasing financial cutbacks, staff layoffs, an unequal distribution of services across the province, closure of beds, a fragmented and uncoordinated component at the community level and a lack of strong linkages between institutional and community care services. Thus, long-term care in Ontario has become an inefficient and poorly managed system.

Bill 173, An Act respecting Long-Term Care, is fundamental to improving this ailing system. Bill 173 will ensure that a wide range of community services are available. It is intended to improve the quality of these services and to simplify and improve access through multiservice agencies. It proposes to develop a proactive approach to try to encourage local community involvement. Long-term care reform will shape the delivery of services to Ontario's seniors and the physically disabled in Ontario.

1050

Overall, Bill 173 is intended to create a system of care that is coordinated and responsive. This legislation aims to reduce fragmented service delivery, as opposed to a multitude of agencies as is currently the case. However, while this vision of a new long-term care system has been in existence for numerous years, there is a deeply rooted concern that there won't be enough money to fulfil it.

OCSCO is pleased with the ministry's commitment to review long-term programs in Ontario. We support the following initiatives and principles in Bill 173: a single entry point to access services to the MSA, a continuum of services, a high quality of service, racial equity and

cultural sensitivity, flexibility in MSAs and, of course, consumer involvement.

I would now like to turn the rest of this over to our co-chair, Bea.

Mrs Bea Levis: There are 11 areas of Bill 173 that OCSCO would like to comment on.

(1) The MSA is one of the most important components of the system. The MSA will be the single access point of entry to the long-term care system. This organization will provide numerous services, such as community support, homemaking services, personal support services and professional services. For those services the MSA can't provide, there will be information and referral service available.

This one-stop shopping centre is to cover a basket of services. However, not all services are mentioned in this legislation. Important services like attendant care, supportive housing, services for the blind and for the hard-of-hearing are not mentioned in Bill 173. OCSCO is concerned that there does not seem to be a rationale for covering some services in the legislation and addressing others in the regulations or completely leaving some out. Therefore, OCSCO would like to recommend that there should be some rationale and flexibility when outlining the services the MSA is responsible for.

OCSCO feels that this legislation is too detailed. As is often the case, it is more appropriate to have the operational details of this reform in the regulations.

(2) Financing the MSA and fee for service: The government will have to ensure that the MSA is continually financially strong. OCSCO sees the potential of an MSA not having enough funds to cover the concerns and needs of its geographic area. There must be a safeguard in the legislation against this. MSAs need secure budgets. No individual should ever be refused a service due to budget cutbacks, fiscal restraint or the inability to pay. Being on a waiting list means no service. Even under the legislation where some services have a fee, there must be a mechanism in place to make sure that the consumer gets the care and service he or she needs. The issue of fee for service must not lead to any kind of means testing or targeting. User fees are counterproductive and this type of social planning is demoralizing and a disincentive for service.

The distinction that is made between homemaking and community support services, where there is a fee, and between professional and personal support services, where there is no fee, is confusing. Seniors will need to prorate time and user fees, particularly if it is the same worker. This is complex and opens the door to implementation of new user fees. OCSCO is strongly against any form of user fees.

(3) Assessment: The appropriate role of the registered nurse and the medical doctor in the assessment phase needs to be outlined. It is important that these professionals must be acknowledged and utilized in the assessment phase and in other areas as needed. Furthermore, the consumer must have as much input into this decision-making/assessment component of their plan of treatment and changes in service.

The right of consumers to make their own choices for which services they wish to receive is often taken for granted. Bill 173 must ensure this right of choice when determining which services in the community, at home or in the institution the consumer requires.

(4) Governance: According to Bill 173, the boards of the MSA will include consumers. OCSCO has often found that seniors are often token representatives. The consumers or seniors are often not part of the decision-making process and often feel that their voices are ignored. When developing the boards and committees of MSA, it is important that the consumer will be given equal representation. In OCSCO's opinion, this would constitute the consumer making up half the board or committee. This consumer should be an individual who is or will be in a position to receive long-term care services. The user/consumer must always be directly involved in the governing and driving of this proposed new system in policy-making and in programming. This would constitute a more equitable system for all who use it. There needs also to be a strong representation from the social services, in addition to the health services sector.

The MSA must be made accountable to the local community. They should be required to have open meetings of the boards, hear deputations and make records available to the public.

(5) Appeal process: Primary care givers, those who care for a frail, sick, elderly or chronically ill family or friend in their own homes, presently have nowhere to go to appeal unjust decisions made by service providers and home care regarding inadequate, inappropriate services or any other forms of grievance. The government must establish an independent review board where primary care givers, the recipients of care and their families may appeal without the fear of repercussions.

(6) Bill 173 has no enforcement mechanism to guarantee that the consumer is getting the best care and services possible. Similar to the standards regarding institutions, Bill 173 must ensure that program supervisors or advisers visit the consumer's home frequently to make sure he or she is being cared for appropriately.

(7) The providers: As we all know, there is a direct relationship between the quality of care and the quality of work. OCSCO is concerned about the lack of regulations for the service providers, the hands-on workers. There has been an increasing number of workers providing specialized care who are scarcely trained or not trained at all. This puts the life of the consumer in jeopardy. Service providers, mostly women, must come under the strict regulations and guidelines which should include proper pay scales, pension plans and other benefits. The increase in unregulated, non-professional care for the elderly and disabled is an evident problem. The generic worker is also of concern. This single occupational designation for community-based workers—a jack of all trades—will result in problems in care and service.

(8) Respite care: In a time when caring for an ill or frail family member is often pushed on to one's family, there is no recognition for respite care. Respite care, a support for the primary care giver, in particular is an important factor in the consumer's aim to age in place.

This issue has been systematically ignored in previous legislation dealing with health and social services. Primary care givers work long and hard hours and often need a break. An initiative often discussed is the availability of unused hospital beds for this type of relief or support. Respite care should be provided at no extra cost to the families of care givers for as long as they need it.

Primary care givers must have support. In particular, there should be a contingent emergency plan for those providers who are either ill or get injured while providing care. Government must recognize that these workers, mostly women, dedicate their life to caring for an ill family member. To most, this would be considered a full-time job. Therefore, these workers should be paid for the services they provide, get reimbursed for out-of-pocket expenses and receive benefits. There should be a clear and concise section in Bill 173 that covers respite care and payment of services delivered by the primary care giver.

1100

(9) Convalescent care: Over the last few years there has been an abundance of patients who have been discharged from acute treatment hospitals quicker and sicker than ever before. These individuals are discharged without arranging for the appropriate in-home care services. These seniors are falling through the cracks. Bill 173 must ensure that home care programs are in existence before the senior gets discharged. A quick response team would be an asset. Another option is to increase the number of beds for transitional and convalescent care either within existing hospitals or in any other care facilities.

(10) Preventive health care: Bill 173 fails to recognize the importance of preventive/wellness programs. For seniors, the social, psychological, recreational, spiritual and many other aspects of senior centres are necessary in order to promote the optimal level of independence and decrease the level of dependence. Seniors use older adult centres and school board programs, to a name a few, to keep themselves physically and mentally active in the community. These programs need to be recognized and funded appropriately in order for seniors to be healthier.

(11) Volunteers: The issue of volunteerism in long-term care services for Ontario must be supported and encouraged. To show support of this very important program, there should be a way to fund out-of-pocket expenses for the volunteers. Many seniors find this a deterrent to volunteering for such programs as Meals on Wheels and transportation. There must also be a volunteer coordinator at all MSAs to maintain and enhance this very important program.

We would like to make one last comment: the funding for this new system. When long-term care reform was in the developmental phase, all players came together on one important point, namely, that the needs of the consumer should come first. This vision has since been lost because many say it is too expensive. We do not want to lose our sense of caring, compassion and understanding.

Governments have again and again stated there is not enough money to fund the vision of an accessible,

equitable and high-quality care long-term care system. Government does in fact have the money to put into Ontario's ailing long-term care programs. It is a matter of priority. Recently the government promised over \$60 million to a new trade centre. A government which is supposed to stand for social justice but seems more concerned about building trade centres and highways has lost that vision.

In closing, OCSO is pleased that the government is taking a proactive approach in long-term care. We feel this legislation makes for a strong beginning to reform Ontario's long-term care system. As we know, the status quo is no longer a viable option. Today's seniors want to maintain their independence and dignity. The quality of life and care must remain the centre point of long-term care. Together we must design a system which will improve any inefficiencies, produce higher-quality care and, particularly, become more consumer-sensitive. Consumers must be assured that the government is willing to move rapidly to implement this long-term care reform.

The Chair: Thank you very much. Just before turning to questions, if I could say to members, we are a little tight and I'd ask you to try to have your question in one, if you might, and we'll begin with Ms Sullivan.

Mrs Sullivan: I'm interested in many of the points that you've raised in your brief. I note for the record, for instance, that you've underlined the importance of the clinical assessment of the person who is seeking long-term care and that you've raised questions about evaluative mechanisms that are available for the home care agency, which will become the MSA. You've raised issues about the generic worker that I think we'd like to pursue at another time, if the Chair would make a note of that.

You've made comments with respect to respite care, and I note that care giver support services are included in the basket under community support services. What seems to me then would happen is that from time to time a care giver who needs a break would have an opportunity for community support through that mechanism.

The point that you've raised, however, is, what if care givers become quite ill or incapacitated themselves, which is a very frequent circumstance. We frequently have two people who are living together, both frail, perhaps one ill, and when the second one becomes ill, there are increasing problems.

You've called for a contingent emergency plan to ensure that the care giver himself or herself receives urgent support. Have you placed that before the government, and how do you see that being involved, say, in a statutory way? Do you see that should be required as part of the basket of services, or do you see that as something that should be allowed for in regulations, or do you see that as something that would be more carefully and better defined by the local agencies?

Mrs Levis: Well, I think probably a combination of all of those on your last point. I think it's important that some sort of a clear guarantee exists—and whether it should be in the legislation or in the regulations I'm not quite sure—that care givers be given immediate support

when they break down, when their health breaks down and they can no longer continue.

We know from experiences when we were preparing this brief, there was a case of a care giver who was very, very ill, and she had to fight and use influence, which she happened to have, in order to obtain any kind of care. It's that kind of thing, and her point was a well-taken one: What if there were, as there are, people who don't know any MPs, who don't know any MPPs, who don't know any of the inner circle? What then happens to these people?

We want to make sure that somewhere along the line, whether it's in the legislation as a general sort of guarantee, and certainly in the regulations, there be that kind of response, that they are entitled to getting care immediately.

1110

Mr Cameron Jackson (Burlington South): I want to thank your organization for a comprehensive brief. You've covered quite a bit of area here, but the general tenor of your brief is supportive. That causes me to raise some questions because, a year and a half, two years ago when the second phase of long-term care reform was before a committee and your organization endorsed Bill 101, we found out that access to chronic care was no longer guaranteed as of right in Ontario. It was removed from the Ontario Health Insurance Act.

We found out that the fee adjustments that everybody talked about in very romantic terms ended up costing seniors \$150 million of increased user fees. Many seniors' organizations wrote to me after Bill 101 and said: "Look, we were betrayed by the government. We were betrayed." Quite frankly, all the same players are here from two years ago. Every single one of the players is still here.

My question is, given now that this bill is going to do the same thing to home care, remove it from the Ontario Health Insurance Act, an as-of-right issue—your brief speaks very clearly about access points and making sure that there are guarantees. How can you support legislation which in it causes the universal right of a senior citizen in Ontario to access a service where fundamentally the outcome is the state says, "Well, look, we just don't have the beds," period, end of sentence? It doesn't have anything to do with your assessed needs being met or whether you're being discharged from the hospital prematurely and with a lingering illness. Basically the state is now positioned to say, "That's not our responsibility because we just don't have those beds."

Do you have the same faith and support for these approaches that you did two years ago or, as your correspondence and other organizations have indicated, are you a little more concerned about the real agenda here and the real outcomes? Because the experience of Bill 101, with its impact on nursing homes and homes for the aged, was a horrendous increase in user fees and the removal of its access point as guaranteed in the Ontario Health Insurance Act.

Could you please respond to that, because all of this is academic if in fact the government has set a pattern and

a direction that will be similar to the one we experienced after Bill 101 was implemented, because it was the long-term care bill as well.

Mrs Levis: I think what we're asking for here is that there be absolute assurance in the bill that this will not happen. What we're asking for is that the right of a consumer to service, whatever that service happens to be, will be ensured. As far as we are concerned, while we accept the basic idea—because in all of the pre-consultations and so on in local areas consumers want an end to duplication and to the rigmarole of having to chase here and chase there and then not know where to get all the services. We want one access point for all the services, and I think most consumer organizations are absolutely agreed on that point. What we want, however, is an additional assurance in this bill that the right to service is guaranteed.

Mr Jackson: So your position is that you do not support the removal of home care services from the Ontario Health Insurance Act as proposed in this bill; that should not be delisted from the OHIP benefit schedule. The minister yesterday said that there are only two provinces in Canada that have it guaranteed in their legislation. She felt there was nothing wrong with removing it.

Mrs Levis: This is something that, I'm sorry, we have not taken into consideration at all in preparing this brief.

Mr Wessenger: Thank you very much for your brief. I always enjoy hearing your brief because it's very good to hear from a consumer perspective with respect to the legislation. I think the point you make is very valid, that really the whole question of services has to do with funding and that if the funding's not there, the service won't be there. Certainly the government has from, say, 1990-91, spent \$550 million on long-term care in the community and by 1994-95 we're going to be spending over \$1 billion, and I think that's a substantial increase in investment in long-term care.

My question, really, what I'd like to ask you about, I was very interested in your comments with respect to governance. Certainly we in this committee are looking for a way to ensure that the MSAs are both accountable to the local community and at the same time have real consumer representation, and you certainly indicate you support that thrust, but I was wondering if you have anything more specific in the way of suggestions of how we might ensure, when we're structuring these MSAs or providing guidelines for them, that we have more real consumer input.

Mrs Levis: Well, I think the section on governance really makes a major part of our recommendation, that the consumer representatives on any boards or any committees that are appointed be what we call real consumers, that is, not representatives of an agency that is serving consumers or representatives of a hospital board, which has happened in some local smaller communities, but people who are in a position to receive the services or are likely to in the next unmentionable period of time. I don't know of any other way to ensure this, other than having a large number of consumers on every board and committee.

Mr Wessenger: So you're really looking at the aspects of ensuring that the majority of the members are not there because of their provider position, that they actually come from the public then, not in the sense of putting further restrictions like saying so many senior reps or so many people with disabilities or something of that nature?

Mrs Levis: That's right.

Mr Wessenger: Fine. Thank you.

The Chair: Thank you very much. I know there are other questions.

Mr O'Connor: Mr Chair—

The Chair: I'm sorry, we have to move on. We're very tight for time. I want to thank the coalition for coming and invite our next witness, Miss Dian Goldstein.

Mrs O'Neill: Mr Chair, on a point of order, please.

Mr O'Connor: The request that I have, Mr Chair, is if our presenters had any thoughts on the bill of rights, maybe they could submit them so we can have that included in the package. Their presentation was so well put together I thought maybe some thoughts they might have on the bill of rights would be appropriate.

The Chair: You can discuss that with them privately after as well.

Mrs Levis: We can certainly do that. Thank you.

The Chair: Ms Goldstein, if you would come forward.

Mrs O'Neill: Mr Chair, on a point of order: I am the critic for seniors for the Liberal Party and I take great offence to the comment that was last made by Mr Malkowski. I think I want to request in writing, and we have a right to—there is confusion on this bill. There is also a misunderstanding on this bill. The last presenters stated that; many presenters yesterday.

Two things I want clarified from the government's perspective. Maybe they haven't even got the answers. Mr Wessenger's question kind of indicated that to me.

The bill of rights is stated by the government to have choice within it. I've read it and read it and reread it; there's not one word there that even recognizes choice or says choice in it. If there are choices there in other words, I'd like to see them.

Community-based boards: I'd like to know how the board is going to be community-based when the actual act says:

"The minister may impose terms and conditions on a designation made under subsection (1) and may from time to time amend or remove the terms and conditions or impose new terms and conditions."

If that isn't centralized designation of agencies and boards, then I don't know what is. Now, if I'm missing some guarantees, it's because I haven't been able to find them, and I have met with endless groups of seniors this summer on this bill.

DIAN GOLDSTEIN

The Chair: Miss Goldstein.

Ms Dian Goldstein: Thank you, Chairman and members of the standing committee. It's good to be back

here once again and see all the familiar faces.

Of course, I'd like to congratulate this government on moving ahead with long-term care reform with this legislation, and particularly, as you mentioned, Larry, for including a bill of rights and an appeal process. Legislation for community services has not ever been available in Ontario and I think they've talked about it since 1954. So although we may have a few criticisms about it and want to see some changes, I want to congratulate the courage of this government for getting it on the table.

1120

You're hearing lots of details and lots of opinions and lots of ideas, and right now I'd like you to just close your eyes and sit back and enjoy an image, whether you will enjoy it or not, of the kinds of people that Bill 173 should serve. This poem is called *Grandma Sits Down*.

Her knees lean against the front of the battered rocker, getting their bearings, while she frowns out the window at the garden, or squints into the poplars to see if the sparrow-hawks have returned. Slowly, flat-footedly, like a fashion doll in the department store, she rotates, knees locked, keeping contact with the chair. Her hands grope for, find, grip the knobs at the ends of the wooden arms. She's not looking at anything now, it hurts, she's concentrating. Holding her breath like an astronaut, knuckles white around the knobs, she lets herself fall. The chair shudders, reels backward, hangs for a very long instant on the coasters' rims (her eyes are shut, head pressed back) and then begins to oscillate. She breathes out: Another successful manoeuvre, nothing to be especially pleased about. She knows not to take for granted she can get back up. Still, the wind of her motion cools her cheeks. She continues with the letter she's been writing: "The earth is beginning to thaw. I am anxious to plant some seeds."

Do remember in these hearings that you are going to be hearing mostly from providers, who may have turf to protect, who may be worried about their own power and control. I refer primarily to many of the professional agencies, who are outside the system at the time. The providers you will hear from are primarily management and administration. What kind of mechanism have we as a group and you as a committee tried using to gain information from homemakers, who are the cornerstone of the MSA system?

Paul asked before, how do we get input? Has there been an opportunity to get lists of people who are users of service and invite them here? Those of us who get information about these committees are part of organizations. People who use service and care givers who supply that service do not have access to this information. Maybe these meetings should be out in the community in a church hall rather than here at the Legislature. Maybe then we would get some users of service.

I have been criticized for talking negatively about consumers as opposed to users of service. Let me assure you that I think it's important for consumers to be here, and in fact I could support every single point that the Ontario Coalition for Senior Citizens' Organizations has made; many of them are my own concerns. They need to have more reflection than just having been read at this

committee, because when I look down again at the list who are presenting to you today, you will have a very biased perspective: all providers.

There is a difference between the consumer of long-term care and short-term care. Many people use acute care services or long-term care services for a finite amount of time. Yes, they're users of the service, but the users of service you want are the people who are in this for the long run, who aren't going to get out of surgery and feel better next week.

The system is in place because of the needs of the client; the client is not there because of the needs of the system. Please keep that in mind when people come, and think of the poem. Will that person get their needs met?

I'm always one for feedback. I see nothing about feedback. I feel there should be an independent evaluation of what is happening in community services. What is the MSA doing? Unless we have an independent way to evaluate ongoing services by all people who go into these homes, we will never know what is happening.

Appeals: I congratulate the government again for including this in its first draft. It needs fleshing out. The appeals primarily are from the service provider's perspective. To me, it is bafflegab. I don't understand them. I just give you one example: I am a user of service. I want to have a bath more than once a week. The agency has told me they cannot afford this. Can I appeal that? Will I feel greedy if I appeal when there may be other people who need to get out of bed in the morning and need help for that or have serious medical problems in their homes? Will I feel greedy? But just think for a minute, ladies and gentlemen, would you feel grungy and smelly if you didn't have a bath for seven days? Do these users of service not have the same rights as you to be clean? Let's not pretend if we're going to have an appeal process.

Regarding program supervisors: You all know I was here with Bill 101 and I have always had concerns about how residential services branch monitors its long-term care facilities. Not well enough, I can say. It's not good enough for compliance advisers to go to facilities, we have learned, and sit in the nursing station and read the charts and look at the record books. To really know what is happening, you want to speak to the residents, speak to the families, see what's happening at meal time. Are residents being fed or is the food going into the garbage? Charts can't tell you this. I'd like to say to you that this is not different from what will happen in people's homes.

Sure, there's lots in this legislation about program supervisors going to community agencies and reading the charts and looking at the record books. What does that really tell them about personhood, about the person in the poem whose knees were locked and could barely stand up again? Charts don't tell you that. How will we know if program supervisors are not in these homes?

Of course, my last point indicated is about orientation. I find so often that users of service, whether they're seniors, the physically disabled, aged patients or families that have children, who are all included under this legislation, don't really know what their rights are. Someone mentioned about the bill of rights. This bill of rights should be included in the handbook and in fact

explain to people what does it mean, what are the rights under the bill of rights.

But let me say to you, there has been a bill of rights under the Nursing Homes Act since 1987. Not that I want people to have to go to court about their rights, but there's never been a prosecution under the bill of rights. I'd like this group to figure out in some way how the bill of rights can be used effectively.

Within your package, I have indicated what questions I think should be used for a feedback form for consumers; I would just like to read a couple of them out loud. Have any community services gone around, and some of them do—and I want to tell you, I may sound critical, but I have a very high respect for the community social services that are providing services in our homes and communities today, but I worry that with the event we have more complex care, more frail elderly, many more people living alone, will the services be able to meet their needs? They aren't at the present time, by the way, and I concur as well with OCSCO, who spoke about the funds and where this government's values really are. I know they're strapped for funds, and I do appreciate it, but I'm an advocate for seniors, so that's where I think the money should go.

1130

Anyway, a couple of questions for consumers: Are you satisfied with the quality of service provided by your homemaker, respite worker, home helper, nurse, physio or OT? If not, what would make it better for you? Do you receive all the services you feel you should receive? If not, what is it that you need and how often? Have you ever felt intimidated by the person providing you with help? Have you complained? If yes, what happened? If not, why? I've given you 19 opportunities and questions there. Again, I see very little about feedback.

The Advocacy Centre for the Elderly has just written a newsletter indicating problems with abuse. I can assure you that abuse is closeted and the 4% that we hear of seniors being abused is the tip of the iceberg. With more people on the agenda, I fear for the abuse of seniors in their homes.

As I said at the very beginning, you will have many providers coming. What are you going to ask them? I know the regulations are important. I know the statute is important. I'm worried about the users.

Maybe questions to them should be: As a service provider, are you willing to give up control and accept the client's decisions and choices? Many do. Many will have more difficulty with that when they have more clients and less time. If you are a service provider, given environmental, fiscal, political and structural realities, can client-driven services be implemented where you work? Are client choices and decision-making supported? Always, sometimes, never, or it depends? Depends on what?

What do we mean by managed care? Is it the resources we are managing and protecting from the client?

I close with another poem. This is called Solitary. This was written for a nursing home resident, so those people who may come from facilities to tell you how lonely

people are in their homes, it's the same whether you are in a facility or whether you are in your home. It also indicates, where the legislation does not indicate, the importance of volunteers in our system. It's called Solitary.

She sits here waiting patiently
And wipes away a tear
Wishing that a visitor would
Suddenly appear.

Someone to say "How are you?"
And greet her with a smile;
Someone to sit beside her
And chat a little while.

It's hard for her to understand
Just what she's doing here;
What's happened to her family
And friends who were so dear?
How come she's been abandoned
Like some worn-out shoe;
What crime has she committed,
What bad thing did she do?

Tho' she has a bed to sleep in
And she's sheltered from the rain,
There's precious little else
Except her loneliness and pain.

She's only one of many
At home alone today
Who finds the price for longer life
Much too high to pay.

That picture could be changed
If all of us would spend
Some extra time just visiting
A relative or friend

Who's shut away from all
That once was held so dear
And needs to be reminded
That friends and service are near.

To take her by the hand and say,
"How are you?" with a smile
And then sit close beside her
And just love her for a while
Is that too much for her to ask,
Too much for you to pay?
Many need a friend and service
Will 173 help or betray?

Again, I am very pleased that Bill 173 is on the floor, even though I have suggested some changes. I thank you for your attention.

The Chair: Thank you, in particular for your questions and your poetry. We'll start the questioning.

Mr Jim Wilson: Thank you, Ms Goldstein, for once again bringing forward I think some very good points, particularly with respect to the bill of rights. If you don't mind, I just thought I'd ask Mr Wessinger what the enforcement mechanisms are in the bill of rights. It's my understanding in the reading of this legislation that a service provider is deemed to have entered into a contract to respect and uphold the bill of rights. That service provider may on occasion be the minister herself, or an approved agency or others. What if somebody violates or fails to uphold the bill of rights? What penalties occur?

Mr Wessinger: Mr Wilson, I'll ask legal counsel to answer that question.

Ms Czukar: The consumer has the ability to attempt to enforce it privately. That's what the deemed contract is about, and we've been told by people that that option needs to be there even though it's recognized that many users aren't able to use that very effectively without some support from advocates or others.

Mr Jim Wilson: Legal counsel.

Mr Jackson: Legal aid.

Ms Czukar: Legal aid, legal clinics.

Mr Jim Wilson: You're into contractual law here, aren't you?

Ms Czukar: Legal clinics would normally help out with that sort of thing in the case of vulnerable people. The other means of enforcing it of course is that where a service provider is an approved agency, which would be the case in most cases, the minister can withhold funding and can revoke an approval where the provider, the approved agency, is in breach of the act. That's the main mechanism for accountability and ensuring that agencies do respect the rights in the bill of rights. It's really a statement of expectations to users about what they can expect from the service provider and to service providers about what the government expects them to do if they're going to continue to receive funding and be approved under the act.

Mr Jim Wilson: Thank you.

The Chair: Did you want to comment on that, Ms Goldstein?

Ms Goldstein: I appreciate the comments that you've made. I do still have concerns about it, because I have watched it for seven years under the Nursing Homes Act and, quite frankly, I haven't seen that it's been very effective. I certainly appreciate the vision, the importance and all of the things that are listed there, but I am not sure that the people who work in the facilities take the bill of rights seriously and apply it at all.

Mr Jim Wilson: I was just wondering along this line, because it's a very good point, would it not be simpler to set up a mechanism that's more user-friendly for, as Ms Goldstein says, the user of services? Okay, you've got breach of contract, so somebody could take private action; why not some sort of—we all understand fines, we all understand that system, where it would be a provincial offence or otherwise for breaching the bill of rights. Can you give us just the legalese around that scenario?

Mr Wessenger: Thank you, Mr Wilson. I wasn't going to give the legal but I was just going to make a comment with respect to this—

Mr Jim Wilson: Suing the minister is a little difficult.

Mr Wessenger: If I could make a comment on Ms Goldstein's concern about how we enforce these, I think we have to remember we can't look at legislation in isolation from other legislation. I think of some prior legislation that has been passed by this government that hasn't been brought into effect yet, that is, the Advocacy Act, which will certainly, hopefully, provide a mechanism for giving greater protection for vulnerable people who are either in facilities or receiving services in the community. That hopefully will be an added protection and

to ensure that the bill of rights is more effectively—

Mr Jim Wilson: But, Mr Wessenger, that's very nice, but all the advocate can do is advise the client or the user of service that they have a right to take private action if there's a breach of contract, or maybe could help them inform the minister so she would stop funding to a particular agency, but you've got to remember that it's kind of strange; the minister also could be acting as a service provider. How does the average user of service easily strike back at somebody who violates their right?

Mr Wessenger: I think that's true with anybody's rights in society. Everybody has rights and you have to have a mechanism for assisting people to exercise those rights, and that sort of depends on what support systems are in effect. If you don't have any support systems, if you don't have any legal clinics, if you don't have any advocacy services, if you don't have any alternative community workers to assist—you have such organizations. For instance, I believe there's a seniors' advocacy clinic, if I remember correctly, a legal clinic. So there are some mechanisms out there and the reality is that rights depend on the support system you have in to assist in the enforcement of those rights.

1140

Ms Goldstein: If I could just say something here, I think the reality is based on fear: users' fear and the government's fear of the industry. I don't know what will happen with community services because I know what their philosophy is based on, and they always try to serve needs. I do know what's happened with the facilities, and I do believe that your discussion of fines is excellent.

When I was on the board of Concerned Friends of Ontario Citizens in Care Facilities, I can tell you that for years we discussed having fines for people who were in noncompliance of the act. We were told at one time that was going to be in the legislation, and it never got in the legislation. There are no fines for anyone, and facilities just carry on providing not good care without any sanctions. There is no reason why they shouldn't continue providing not good care. So we have discussed the issue of fines when it's come to facilities. I hope there won't be a need to in this case, but I think they should be there to back it up, because my feeling is we won't be looking at this legislation for a really long time and I'd like it to be done right a little bit this time.

Mr Malkowski: Thank you for your presentation. It's very comprehensive and very helpful to those of us here on the committee. You've raised some very good points and concerns, and we hear your words; they're important to us. I also would like to congratulate you on your teamwork in your presentation, on the first MSA, on the work that you've done with the minister. I want to congratulate you on the work that you've done in the past.

I come from the riding of York East. We've been very active. We have very active service providers and consumer groups, and the DHC has been working very, very hard with the local community groups. It's very exciting to see how things have evolved.

I'm wondering if you could tell us a little bit about the

local DHCs, leading and planning, which way you think they should go. Could you tell us a little bit about that?

Ms Goldstein: Thanks for putting me on the spot. I suppose I'd see myself in a bit of a conflict of interest here. But what I can say about the local DHC is that I'd really like there to be more resources for the district health council in Metro Toronto to be able to involve front-line workers, consumers, care givers, volunteers, and any community agency that would like to be involved at the DHC level to do their planning.

The problem is resources and the number of people I understand are at the district health council. I've worked very hard in that process but I also recognize that a lot of people feel their views and their input have been left out. If there would be any way that we can incorporate more people to be involved in the process, it would please me.

Mr Malkowski: Thank you very much for all your efforts and your volunteer work, the time. It's been very challenging, I know, and we look forward to working with you in the future and thank you for your feedback.

Ms Goldstein: Thank you, and I continue to work hard.

SENIOR LINK

The Chair: I call our final witness for this morning, representatives from Senior Link. Welcome to the committee, and would you be good enough just to introduce yourselves to the committee.

Mrs Judith Leon: I'm Judith Leon, the executive director of Senior Link, and Marilyn Pratt is director of planning and research.

Mr Chairman, it's a bit hard for me to come and talk to you as a manager of one of those iniquitous agencies that Ms Goldstein just spoke of. I'm a bit surprised by what she had to say because for years she has brought her students from Ryerson to Senior Link every year and talked to them extensively about how marvellous Senior Link's client-driven services were. Perhaps afterwards she'll tell me what on earth we've done wrong that she would suddenly apostrophize us as being money-grubbing people looking out for our own self-interest.

Senior Link is a neighbourhood agency which was started very much entirely by consumers or users of service who were not getting the service they needed from the big, established agencies like home care and the big services in Metropolitan Toronto. It was started by a group of local seniors.

I happen, by background, not to be a nurse, not to be a doctor or social worker. I'm a prehistoric archaeologist by training, but I also was a political flack in Britain many long years ago and I was asked to become involved with the agency because they needed access to money and help. And because of my particular background, I tended to know how to access you gentlemen and ladies around this table, which enabled us to provide an alternative to the established services then available 15 years ago in Metropolitan Toronto, where one saw case after case of seniors dying in their own homes from lack of help because they were unable emotionally or physically to ask for help or, when neighbours asked for it, the people did not conform with some rule or another.

I don't wish necessarily to criticize home care per se. They have rules which they were bound to by the governments who set up their terms of reference. But be it as it may, most services in this city now, or in this province now, are geared to certain services. They're not geared to the needs of the individual senior who approaches them. They're certainly not geared to the many, many seniors who need help but do not know how to approach them.

This bill that you have before you now is the government's recognition, I believe, that services to seniors not only are fragmented but, much more importantly, are wrongly focused. It has been a long time now that there has been ample research that homemaking and personal care—which is what home care does—and some of the nursing services, though good in themselves, do not decrease institutionalization. This is contrary to what many people say, but the research in Europe is very clear. You can increase the amount of homemaking going into an individual person's house by manifold and it will still not decrease the level of institutionalization.

What the Europeans have found and what I think was the aim of the government when it first began to work on Bill 173, though it's gotten lost in the process, is that what you need is, if you want to be formal, a case manager—if you want to be informal, as Senior Link does, a community worker—who can go into that house and act, if you like, as a surrogate son or daughter to the person who needs help. I don't mean that they are a son or daughter in personal terms, but in the sense of the things you would do for your mother or father if they were alone and in need of help: the finding of a workman to fix a roof, the sorting out of a row with a neighbour over a tree that's fallen down, anything like that which is going to help the senior function within their own home, as well as the more obvious basic needs of homemaking and crisis intervention.

The research has also shown that small agencies deliver services in a far more client-focused—or consumer-focused, as we now call people; the words change, whatever is current at the moment—way. When a staff person of Senior Link goes into the home, their object is to find out what the senior wants and, if possible, deliver it, whether it's a paid service that they can arrange or an unpaid service for which they have to find a volunteer.

I think that's what the government wants when it has introduced Bill 173. Unfortunately, the people who drafted the bill, I think, or the way in which the bill was written, it's really a rewrite of a previous government acts. It doesn't reflect on the new ways which have been developed of helping people. It's not authorizing neighbourhood multiservice agencies to deliver all appropriate services at the seniors' and their own best capabilities and it's not authorizing envelope budgets.

What should be happening, we feel, is that the agencies which are responsible, these new MSAs, multi-service agencies, should be told: "You go and do anything that you possibly can that the senior needs help with, whether you do it through a paid source or a volunteer source, and you use an omnibus budget. We're not going to tell you you have to have two hours of

homemaking and one hour of personal care and three hours of transport and two hours of meals, or whatever it is, in a rigorous, set form for which there are a kazillion rules. We're going to tell you to provide that service as best you're able with the money and volunteers you have and then we will send in top-of-the-line operational auditors."

1150

They do not exist in Ontario at the moment, but it's not hard to set them up. Those operational auditors can then determine that the agency, the MSA, is doing its job properly by visiting every 87th name on the database of seniors or by going out and checking a street on their own to make sure that all the seniors who need help are actually getting it.

There have been two objections to what I have to say. One is that the services have to be the same throughout the province, and that if one agency does something differently from the other, this will be wrong. I think that's nonsense. Obviously, seniors should be able to get services anywhere in the province, but different areas of this province have vastly different needs in terms of what the seniors who live in those areas want.

The second objection to the matter of envelope budgeting is that much of the money that Ontario uses in fact comes from federal-provincial cost-sharing and that the feds require that one statistize how much service is being given for their money. There's no reason, however, why MSAs that keep statistics till they're coming out of their faces can't keep the appropriate stats. There's also no reason why Ontario cannot go to Mr Axworthy's review of the social services and say, "We want to change the ways in which we account to you for federal dollars."

Senior Link therefore recommends that MSAs, as a global program, be empowered to deliver appropriate services with a global budget and that their effectiveness be ensured through the use of detailed, personal operational audits.

Comprehensive service is one of the buzzwords that everyone uses, but in this act you have long lists of things which are going to be included. There are equally long lists, ladies and gentlemen, of things that ought to be in that act—and some of the people who were speaking earlier this morning mentioned them; supportive housing was one of them—but which are not. So really the act is predetermining what the MSAs should be delivering, and I think this is very regrettable.

As I mentioned earlier, a lot of research has shown that what people really need is that one person who goes in and helps a senior as they're beginning to need help. Initially, it might just be organizing somebody to mow their lawn or do their shopping in the middle of winter because of the ice on the street, nothing very much. But that same person, not somebody different every time like happens with all these big agencies, being responsible as the senior or the other people who come within the tenet of this act need help.

It's not somebody who's going to say, "Well, it's not my job to do that" when they come into a house and

discover that somebody's had diarrhoea and there's a mess scattered around the floor. It's not somebody who's going to say, "Well, I'm sorry you're being evicted from your apartment, but you'll have to go to legal aid or something because that's not my job," because most seniors, when they become so frail that they need the kind of help that agencies like we give them, are not emotionally able to go and find the people who should be helping them. Those people may be there, but they aren't emotionally able to access them.

It needs a community worker or a "case manager" to go out and find the public service lawyers or whomever it's going to take, find the owner of that apartment building, cajole him to change his mind, promise to help the senior clean up if the senior's being evicted because the apartment is filthy, whatever it takes.

That kind of community worker is the most important part of keeping a senior in their own home, and by whatever name you call them, community worker, case manager, client intervention worker, they are not mentioned in this bill at all. If we must have the system of listing things which have to go into the bill, then if I may, I would like to recommend the inclusion of client intervention and assistance within the bill.

A few minutes ago, I was talking about problems the senior might have in their home with, say, a neighbour or a problem with a tree or work orders on a house where public health or somebody has put work orders on a person's house. One of the things this client intervention worker would be doing is fighting with whatever authority is trying untowardly to intervene, to help the senior. Quite often, for example, public works or the public health inspector, and I don't mean public health nurses, will try to turn a senior out of a very dirty house because, "It's for their own good to live in a nice, clean nursing home."

You may wonder why I'm a bit belated speaking of this when it should have been in front of you for the Advocacy Act, but the point is, formal advocacy is all very well that you've set up in your advocacy acts. What it doesn't include, and what is more common, is the informal advocacy where a client intervention worker will try to sort things out before they get too bad. That happens in my agency. Maybe six or seven times a week we deal with that kind of informal advocacy. It's very cheap, it's very cost-effective and then the senior doesn't have to have strangers coming into their home to be formal and rather scary advocates. So we recommend the inclusion of informal advocacy in the list of services that should be provided.

One of the most serious omissions in this bill, to me, is its failure to obligate the MSAs to search out the people who fall between the cracks. Technically, this bill is setting up yet another of the long stream of vertically integrated organizations; that is, organizations which are judged by how well or badly they serve the people whom they have accepted as clients.

Senior Link has always believed, and a lot of modern research confirms this, that horizontal integration is the only measure of real value. That is a technical term meaning, how many of the people out there who need

help are getting it, and then what is the calibre of the help? It's all very good for organizations to go around saying, "We provide 95% of the help for people we've accepted as our clients," when out there there are people living in untold misery in their homes who aren't able to access the system. It's not that the system won't help them if they do access it. They don't know how to access it; they're not able to.

It's no good putting little letters in pension forms, because 60% of seniors are functionally illiterate and cannot read those pension forms. You have to go and knock on the door, year in and year out, and that's what MSAs should be required to do. It's done entirely by volunteers. It doesn't cost anything. It's not a dollar issue. You simply say to all three local political parties: "Look, guys, we're doing a canvass in May. If the Tories are giving us 25 people to canvass for us, will the NDP give us 30?" You get those people to come and help. It works very well. It finds the people who slip through the cracks.

I think you have to put something in this bill and we would recommend that MSAs be mandated to provide horizontally integrated services.

We think also that there is a problem with saying that there are four years for transition and then everything shall be part of the MSA. In terms of services like homemaking, I think this is quite legitimate. Homemaking is primarily housecleaning and personal care. All local agencies do that anyway. That's readily done within a local community.

In terms of the nursing services, this is slightly iffy. The basic nursing services should work out of the MSA as a part of the MSA on secondment from one of the big nursing agencies, but I think the specialist nursing services, the IV stuff, that kind of specialist nursing service, is best left in a big regional body like the VON or Saint Elizabeth nurses, where one contracts for those special services to the MSA when one needs them at a predetermined and reasonable cost to the MSA.

1200

What we're recommending is that, instead of saying those services will be enfolded into the MSA at the end of four years, at the end of, say, two operational years you review the service and see how it's working as a secondment model, and if it's not working well, then by all means push it into the MSA, but if it's working well, then reconsider it.

I should say we have no nursing contacts whatsoever. I'm not doing this as a member of any nursing body of any kind, shape or form. It's purely that as a community agency we think this would work quite well.

My final point, and it's just a point for you to think of, is I think your appeals procedure is quite unworkable. By allowing anyone to appeal at any time, you're not only getting the people Dian spoke of who certainly need to get around at the agency and do an appeal quite genuinely, but you're also getting all the manic-depressives and people of that nature who make a habit and a lifestyle out of complaining and appealing five times a week. If you have a procedure which automatically accepts anyone

who's complaining to go to an appeal, your appeals will get totally bogged down.

We're just suggesting that you might like to require that people go through a procedure with a local MSA, with the supervisor or the executive director or the board of the local MSA, before they appeal to a provincial body, simply for convenience sake.

Ms Carter: I can see why Dian Goldstein smiled when you said you were one of these terrible providers, because you're obviously nothing of the kind, you're very consumer-oriented and dedicated. What you've been doing is to give us some policy suggestions. Obviously, this act is not cast in stone. It will be amended and I think some of the things you've been saying may be grounds for possible amendments.

In that vein, I wonder if you could tell us: Supposing it just happened that in the way things panned out in your community, Senior Link were the MSA, how would the kind of drive and consumer-oriented focus that you have been carried through and transferred to the whole area of the MSA?

Mrs Leon: One of the problems, Ms Carter, is that we still don't know and have not got any statistics of how many people would likely be part of an MSA, given any predetermined size. My best guess is that if East Toronto were to have two MSAs, one in Riverdale and one in the Beaches, which is my area, my agency, which has a present budget of \$7 million and a staff of about 40, would have a staff of maybe 400. That's a guess.

If Senior Link were the MSA, we would be adding to our ranks a great many home care workers and nurses. The nurses we work with very closely already, so that would be no big problem. Home care workers would—and many of them are very able people, but if they were part of a Senior Link MSA, they would have to learn a great deal more of taking responsibility for themselves, because we tend to believe it's the person working with the senior who should make the decisions, once properly trained, which doesn't happen in these big, huge organizations. They would have to learn that it's what the senior wanted that happened rather than what the rules say. Senior Link doesn't pay a whole lot of attention to rules, I'm afraid.

The big problem, though, at the moment is that in Metropolitan Toronto the district health council, for its own reasons, and far be it for me to say what they are, has decided that MSAs will be big, huge organizations. At the moment it's going to require major, major advocacy for Senior Link, or an organization of Senior Link's size, to remain. The theory is that we get closed down and a couple of neighbouring agencies get closed down and then some huge amalgam takes our place. It won't work, in fact, because only about 20% of our funding comes from MSA dollars. So in fact, if that were to happen, that scenario, we'd have far more fractured seniors' services than we have now.

Ms Carter: We have been told by various presenters that we would lose the volunteer component under the provisions of the act because somehow people wouldn't want to work for big government bureaucracies. They want to work for specific agencies or specific groups of

consumers. We certainly don't want that to happen and we see the volunteer component as a very necessary and ongoing one. So what can we do to make sure that prophecy doesn't come true? Surely, the answer is that the community has to be involved. It seems to me it is involved and it's going to continue to be involved. How can we make sure we keep the volunteers?

Mrs Leon: Ms Carter, Senior Link has I think about 25,000 hours a year of volunteer service; a lot for a small, local organization. If a new MSA were to be an organization of the size of Senior Link, which is roughly a city ward, give or take a bit, then I don't think you have any problems with your volunteers. But if what's happening in Metro Toronto's DHC is the norm throughout Ontario, which I gather it is, the powers that be are deciding—not your government but the people who are implementing the government's decision—these MSAs are going to be huge, and no, you wouldn't get any volunteers working with them.

Mr Dalton McGuinty (Ottawa South): Thank you for your presentation. I just want to follow up on the distinct possibility, and I guess it's a probability, that we're going to be dealing with large MSAs in the future. What is going to happen to your employees?

Mrs Leon: If the MSA is not Senior Link, most of them will be unemployed, I suspect. The reason for this is because if there are these huge organizations, then everyone who works within the system will be entitled, obviously, to apply for a job within the new organization, along with hospital workers and a whole bunch of other people. But what's going to happen with those huge organizations, I can absolutely guarantee, is that the people who run them are going to be the existent, fairly powerful bureaucrats in Metropolitan Toronto in the various systems that you're closing down, and without exception, those people do not interview and hire on the grounds of, does this person who's going to be a community worker or—well, they won't be community workers under that system, but does this person understand seniors, do they care about seniors, are they good advocates? They're going to be interviewed on: "What are your academic qualifications? Do you have a master of social work degree? Are you a nurse?" If not, you go right to the bottom of the list. Senior Link, I'm afraid, has always chosen to hire on—we have people with very high academic qualifications and we have people who were former waitresses in restaurants.

I should tell you that by no means do high academic qualifications make good people working with seniors. I personally am awful when I go into a seniors' house. I just do not have the particular skills of knowing, does this person want to be touched, does this person want me to keep two feet or three feet distance, how much does this person want? I happen to be more of—an organizer, if you like. But you have to hire the people who instinctively know how to deal with other human beings and it doesn't matter a tuppenny damn whether they've got degrees or not. You can teach them what they need to know, and you certainly have to teach them—I'm not suggesting one sends untrained people out for one minute—but they can be taught internally or at a few

good courses. Humber runs superb courses in community work and some of the others do too. But those aren't going to be the people who get hired.

Mr McGuinty: If the alternative is between the status quo and larger MSAs of the kind which you've just described, which is your preferred alternative?

Mrs Leon: I would dearly like the system reformed, but if the reform is going to mean large MSAs, I'd prefer to stay the way I am because now I can play off home care against the VON, against Saint Elizabeth, and somehow or another, I'll find somebody to come and provide the professional help which my staff aren't capable of and do not wish to be capable of doing.

1210

Mr Jackson: Judith, good to see you again, welcome. At that pause, when you were about to describe the type of person you are, you're more of a powerhouse than an organizer. I recall when you impelled me to come and visit your facility and spend half a day with you, and Mr Wilson as well, several years ago.

Mrs Leon: You're welcome again.

Mr Jackson: It was an eye-opener in the extreme, and I couldn't help but be struck by, every time a need appeared during your evolution, you found the resources and, more importantly, the human resources to respond to that need. Therefore, there's almost an analogy that you could be defined as the perfect MSA because you already are one-stop shopping and you provide a basket of services.

For those members who are unfamiliar with Senior Link, you provide housing, you provide every range of support and if you don't, you will go and find that. In many respects, you're what's good about the system we have currently but being cast as what is requiring reforming and tinkering with. I want to thank you, first of all, for putting that in perspective for the thousands of seniors you serve, and maybe you could remind me of the actual ward in Toronto that you—

Mrs Leon: It used to be ward 9. It's now a mixture of 10 and 9.

Mr Jackson: I certainly think if the residents of that community were able to speak before the committee, they would indicate many of the elements of the one-stop access and responding to the needs with the kinds of caring professionals.

The themes that you've raised in your presentation were presented yesterday as well by Catholic agencies in Toronto, and they were talking about their ethos and their mission statement. This really had very little to do with being Catholic; it had everything to do with their approach. I think there was some confusion on the part of some members, but quite frankly you have that same ethos and that same mission statement and purpose which you bring to your organization.

How are the current discussions affecting you in your specific area with respect to your relationship within the MSA? Have you had any indications what role you may be called upon to play or whether the grand plan is to phase you out or if the grand plan is to attempt to integrate your capital assets but not necessarily all your

programs? I'm convinced that under the MSA there'll be less breadth of service. You talk about horizontal integration in your report, and therefore I can see, almost, your organization being cherry-picked for its best elements and the rest abandoned.

Mrs Leon: Cam, you were kind enough to refer to Senior Link as a typical model of what an MSA should be, and in fact I would say that when Frances Lankin was the Minister of Health—she happens to be our constituency MPP and she did in fact base her initial thoughts, and makes no secret of the fact, on what she knew of Senior Link, which was extensive and detailed. She's been a very loyal constituency MPP to us. But somehow during the development of the MSA process, as it got out of the politicians' hands and into the hands of the developers of the process, something went skewed and it went back to versions of the old system.

In terms of what would happen to Senior Link, if we were to win the battle which we are currently fighting, then we would be the MSA with the extension of the home care workers and people of that nature. However, the district health council, I understand, is very vocal in saying that we will not win this battle and that there will be one huge MSA for east Toronto. They are totally ignoring the fact that both the neighbourhood agencies, which are ourselves and WoodGreen Community Centre, own 80% of—none of our capital goes nor legally can they take it. I have checked that with very high-powered lawyers. It's ours. The United Way and Metro community services have both made it clear that their moneys will continue to go to the two community agencies if we stay in existence, and we'll lose 20%, or 25% in WoodGreen's case, of our money to an MSA which will be out there.

This will devastate both of our agencies because it's impossible to provide supportive housing. Senior Link has about 350 units of supportive housing. We cannot provide it if we don't have the community workers to integrate with the housing people to provide that service. What we would do would be to turn Senior Link into a housing and advocacy agency and advocate against the problems that the new MSA almost certainly would have.

The Chair: Thank you. I'm sorry there isn't further time. We should probably also underline that this is a unique presentation in that I doubt we have had before a presentation by a prehistoric archeologist, nor are we likely to have one subsequently in our hearings. We thank you both for coming this morning.

The committee stands adjourned until 2 o'clock.

The committee recessed from 1216 to 1408.

SOCIAL PLANNING COUNCIL OF METROPOLITAN TORONTO

The Vice-Chair (Mr Ron Eddy): Welcome, ladies and gentlemen. We're a little late getting started. The first presentation is by representatives of the Social Planning Council of Metropolitan Toronto. Would the representatives come forward and proceed with your presentation. We hope there's time for questions.

Mr Peter Clutterbuck: I'm Peter Clutterbuck, with the Social Planning Council of Metropolitan Toronto. Mr

Chairman, members of the committee and ministry officials, I appreciate this opportunity to talk to you today on Bill 173, An Act respecting Long-Term Care. I've distributed copies of the brief with some appended material.

I was hoping to be sharing this presentation with several of my colleagues from social planning councils in the greater Toronto area. Unfortunately, timing and last-minute family business have not made this possible. This presentation, then, is officially being made on behalf of the Social Planning Council of Metropolitan Toronto, which is an independent community agency in the voluntary sector dedicated to social research and policy analysis on issues relevant to the social wellbeing of Metro Toronto's residents.

I did, however, in preparing this presentation draw from the deliberations over the last year of the Social Planning Network of Ontario on the integration of health and social services in the province. The Social Planning Network of Ontario is made up of more than 40 community-driven social planning organizations across the province, including the Metro Toronto SPC. I also did have a chance to talk about my message here with Paula DeCoito, the Peel Social Planning Council executive director, who unfortunately had to cancel her appearance here today.

Long-term care reform in Ontario has been a project of the last three provincial governments since the early 1980s. The Conservative government's minister for senior citizens' affairs proposed A New Agenda in 1986, followed by the Liberal administration's Strategies for Change in 1988-89, and finally the current government's Redirection of Long-Term Care and Support Services in Ontario in 1991. Each administration and many ministers with a variety of associated responsibilities for the reform project have tackled the complex web of issues involved. Some community groups have expressed much frustration at the lack of action to date. They may well be pleased at the fact that there is finally a bill on community services integration before the Legislature. That does mark progress in one way, but it is as important to understand fully the implications of what may be done in Bill 173 as it is to proceed with some form of action on long-term care reform.

The Social Planning Council of Metropolitan Toronto has maintained an interest in this latest reform since the Strategies for Change consultation process. A community forum attracting more than 200 participants in January 1991 led to the formation of a long-term care community coalition of concerned individuals and agencies which the SPC convenes regularly for review and discussion of reform developments. The long-term care coalition has made representations to the relevant ministers and ministry officials on issues which have emerged since the Redirection paper was released.

Most recently, the Metro SPC has prepared and released to its membership and the larger community a Social Infopac which summarizes and offers commentary on Bill 173. This has been appended to the brief which was distributed to the honourable members, and I ask you to consider some of the issues that are discussed in the

infopac. I'll not repeat the specifics raised in the infopac, but wish here to highlight several overriding issues of concern with respect to Bill 173. They are the integration of health and social services, the dominance of the health model, and the dilemma of policy prescription versus policy avoidance.

First, on health and social services integration: From the government's perspective, the objective of long-term care reform has been to organize and manage an integrated system of health and social service delivery for seniors and physically disabled people in Ontario. There has been strong community demand for a better-coordinated system of community and institutional supports. There has also been growing concern about the social and economic costs of early institutionalization versus supporting people in their homes and communities. Long-term care reform has also been touted as a forerunner or prototype for more comprehensive integrated service approaches for other populations.

Bill 173 makes some useful strides towards the concept of integrated community services. Subsections 2(2) through (7) of part II describe four types of community services which fairly comprehensively range from basic daily living supports—community support services and homemaking services—to more extraordinary and specialized assistance—personal support services and professional services. The range of services listed gives some sense of both the distinctiveness and the complementarity of health services and social supports within one system.

The plan for service described in part VII is one integrative mechanism which may provide a degree of individualization for people needing support. The overall force, however, of the references to the plan for service throughout the bill suggests a relatively passive and reactive role for the service consumer. There is an assurance of consumer protection under section 3 in the bill of rights, but it really cannot be so confidently made when persons needing service are dependent on the resources of the approved agencies, which they are expected to challenge as service shortfalls occur.

The primary integrative structure in Bill 173 is of course the multiservice agency described in part VI. Designated by the minister, MSAs will have both direct service and purchase of service powers. There is not much further development of the MSA model within the main body of Bill 173. The structural and operational dimensions of the MSA model were much simplified by firmly incorporating it and its community services integration functions within the Ministry of Health, and this, in our point of view, is the main problem. There is real hope here for a strongly integrated approach conceptually in the bill, at least in outline form. The main problem is how that is going to be administered or actually carried out.

Health model dominance: The long-term care reform of Bill 173 is clearly driven and controlled through the Ministry of Health. Early in the life of this government, long-term care reform, or redirection, was a triministerial initiative with the lead responsibility resting with the Minister of Community and Social Services. Although the ministries of Community and Social Services and of

Citizenship remained identified in the policy documents released in 1993, Bill 173 finally sheds both and institutionalizes responsibility for integrated community health and social services in the Ministry of Health. This is explicit not only in the act under consideration, part V, but also in the proposed amendments to relevant acts which transfer authority for homes for the aged from the Minister of Community and Social Services to the Minister of Health.

The bill's proposed amendments to the functions of district health councils in part XII, in conjunction with the Health minister's powers of delegation of ministerial authority in part XI, also make it clear that district health councils will act for the minister on the implementation of an integrated community services system. In fact, district health councils in Ontario have exercised this mandate for more than a year now with respect to long-term care planning. The amendments to the Ministry of Health Act on the functions of DHCs also prepare the ground for a larger role in future human services integration initiatives out of the Health ministry.

The members of the Social Planning Network of Ontario are concerned that the long-term care implementation process reflects primarily a top-down, highly centralized, professionally driven corporate planning strategy. Community involvement has been limited to consultation rather than ongoing participation and decision-making. This approach risks producing an integrated service system for seniors and disabled people which is not accountable to community and which is unbalanced in terms of its health versus social support components. Social planning organizations are well situated to bring the community-based social support perspective to the planning process for an integrated health and social services system. Our role as planning partners, however, has not been recognized nor fully exploited.

The Metro Toronto SPC has joined with its more than 40 province-wide community planning partners in the voluntary sector to express strong concern to both the ministers of Health and of Community and Social Services that integrated health and social service planning in long-term care is being driven by the health model. There is a wealth of experience and community knowledge in social planning organizations across the province which has not been adequately supported by either ministry in the implementation of long-term care reform.

Local planning advisory committees have been organized, and in some cases social planning organizations have joined these discussions, but they have been invited to do so as stakeholders in the system rather than as planning partners, and they have been expected to participate in this major planning initiative without additional resource support. With the withdrawal of the Ministry of Community and Social Services from even a shared leadership role in the reform effort and the clear intent of Bill 173 to further empower district health councils, there is little likelihood that independent community planning bodies will have any meaningful role in the future development of an integrated system in this province.

This is a sadly missed opportunity. A truly balanced

approach to integration would have involved joint policy leadership out of both ministries, definition of a shared mandate and allocation of adequate resources for health system planning and community support planning bodies to work effectively together.

While district health councils may recruit from the community and make every effort to reflect the composition of their communities, they remain professionally and institutionally dominated and, district health council members being appointed by the minister and serving at the minister's pleasure, their accountability is to the minister and not to the community.

Ironically, while institutionalizing centrally controlled planning in long-term care, Bill 173 actually reflects in other respects the very limitations of that approach, and that's why I'd like to conclude with the policy dilemma that's presented.

Bill 173 plots an inconsistent course between policy prescription and policy avoidance with the always fail-safe provision that almost anything can be done or undone at the minister's discretion anyway. Major policy decisions are hedged. For example, multiservice agencies will be designated for a geographic area which might be periodically altered at the minister's discretion, but there is also provision for multiple designations in or within one geographic area.

In addition, municipalities or boards of health will not be excluded from MSA designation but will only be considered after all other approved agency options have been considered. Section 12 mandates MSAs to "provide or ensure" community services in their designated areas but places a 20% budget limit on purchase of services in the four community services categories. This seems to be some kind of accommodation between the pure service brokerage and the direct service models that were talked about at one time.

Other issues which were once to be major parts of the policy framework are hidden or relegated to the regulations for determination. The issue of user fees for community support and homemaking services, a seriously contentious policy issue in early 1991, is buried in section 25 for determination in the regulations. Subsection 56(1) lists 41 areas for the Lieutenant Governor in Council to make regulations, a number of which are critically important policy issues, such as determination of funding arrangements, selection and composition of boards of directors of approved agencies, the addition of functions and duties to approved agencies. At one time in the development of long-term care these were the issues about which a limited number of options were being assessed for policy consideration. There is no treatment at all of an important policy area: support to family care givers.

What does this overreliance on regulations and ministerial discretion in Bill 173 suggest? We think essentially it suggests that the government has encountered a wide range of policy preferences in the community reflecting the real diversity which exists in long-term care reform across the province, and rather than explicitly testing a number of approaches with intentionally different features in order to inform the development and adoption of a

flexible but coherent policy framework, the government has chosen to resolve its policy dilemma by avoidance through use of its regulatory powers and practically unlimited ministerial discretionary authority.

1420

To conclude, it is difficult to make specific recommendations on Bill 173 addressing the issues presented above without fundamentally altering the very nature of the bill. Clearly, the social planning council feels that the joint ministerial approach initiated by this government should have been carried through to the legislation. Stronger support for active community participation and local planning processes should have been provided.

The one opportunity which seems to present itself is the fact that a comprehensive and definitive policy framework for community services integration is not resolved in Bill 173. Much is left to ministerial discretion and the regulations. This could allow the testing of a variety of integrated service delivery models which, over time, could inform the definition of a more coherent policy framework. This would best be an explicit and intentional provision of Bill 173, with a statutory review date five years or so down the road. Of course, any such initiatives should make provision for an effective working partnership at the policy level between the two principal ministries and, at the district and community level, between the health system and the community planning bodies, which both have strong networks throughout this province.

Mrs Sullivan: Thank you very much. At one point in your brief you have mentioned the issue of charges for services, and this issue was raised earlier today by the Ontario Coalition of Senior Citizens' Organizations. If I can just read to you what they say in their brief: "The distinction that is made between homemaking and community support services, where there is a fee, and between professional and personal support services, where there is no fee, is confusing. Seniors will need to prorate time and user fees, particularly if it is the same worker. This is complex and opens the door to the implementation of new user fees. OCSCO is strongly against any form of user fees."

You've mentioned the conundrum of fees for some services and no fees for other services. I wonder if you would comment further on the observation the seniors have made, that the new model, where there may well only be one person doing friendly visiting, Meals on Wheels or other personal support services, and where there are provided some of what used to be Comsoc services, perhaps right alongside some health services, and where there are different federal government transfers to the province, which I know you're familiar with—how do you see this all shaking out?

Mr Clutterbuck: Whether we're talking about social services or health services in our community, the strong bias, in fact the push, is for more support at the preventive end of things: programs and supports which help people stay in the community, stay in their own homes and not have to use more specialized forms of care, and certainly to avoid institutionalization if at all possible.

It seems, then, a bit ironic that one of the areas in

which we want to implement user fees is right at the basic, daily community living supports that people with these kinds of needs require. I'm sure the Ontario coalition of senior citizens knows very well the concerns of its members. Apart from being confusing for them in terms of what they pay for and who they pay for it—and I think within the bill there is actually provision for these individuals being designated as collectors of fees, which we think is inappropriate—apart from the confusion to individuals, if we're really serious about preventive and community health measures and programs which avoid institutionalization, we should be putting our heavier investment into these types of activities: supporting people's daily and community living needs when those are obvious and require that kind of support. So I would agree with the Ontario coalition of senior citizens in that regard.

Mrs Sullivan: I guess the concern is that the seniors themselves will have to be making some determination, or the client—it may not be a senior—will have to make some determination about what hours or what proportion of time is used for what services.

Mr Clutterbuck: Yes. There's another issue here. I think Evelyn Shapiro from Manitoba a few years ago—I wasn't with the council then, but I believe she presented at a community forum. I know she presented at a community forum at the social planning council on long-term care reform in Manitoba, and I remember that one of her comments at the time was that the creation of a fee structure and differentiation for different types of services does lead to some need to administer it, some need to track it and some additional costs, which she wondered—she didn't conclusively say—in fact wouldn't have paid for itself if they just paid for all the direct services to people.

Mrs Sullivan: I'm interested in your comments about the integrated system and the predominance of health issues in this model. We've heard, I guess from York Home Care and from at least one other presenter already who have indicated that as part of their client base, 90% of their clients have an acute problem that has to be dealt with in association with some of the other support services that are being provided. As a consequence, if there is a health emphasis, it may well in fact be met through this model. Would you comment on that?

Mr Clutterbuck: I think one of the issues might be, you know, we all have a health interest. Health is an issue for all of us. I guess one of the real concerns is how much we have to rely on medical forms or more specialized forms of assistance for people, which tend to be more costly, and when appropriately given or made available to people certainly are appreciated and respond to very specific needs.

The real challenge I think in terms of supporting people in the community is to be able to more and more provide for more specialized and even medical needs to people who require them in their own homes and communities for as long as possible and to have to resort to the institutional placement as strictly a last resort.

There have been some experiments, in Vancouver, for example, and in places like San Francisco, where people

who are fairly highly medically involved in terms of their needs do receive a fair level of support in their homes and communities, even with the transportation of special equipment sometimes to their homes for shorter periods of time so that over the longer term they don't have to reside in the nursing home or institution but might get periodically concentrated forms of specialized assistance that helps them deal with a crisis but also stay in their own home.

Mrs Sullivan: I think that's the one aspect this legislation contemplates that I favour in fact, that there would be home delivery of services when that was appropriate in terms of the treatment needs of the individual and where it's cost-effective and so on. Indeed in Ontario there are some very sophisticated treatments now being done in the home, not the least of which are chemotherapy and dialysis.

I'm not certain that therefore I can concur with your concerns about a health dominance when the evidence is that the first reason people are coming into the long-term care system is usually a health problem requiring a clinical treatment.

Mr Clutterbuck: That might well be the case in terms of why people might actually get it, but presumably there is some recognition of the fact that there is a need to bring together social supports and health supports in a more comprehensive system for people.

Mrs Sullivan: I don't think there's any question about that.

Mr Clutterbuck: And the real question, if we were strictly limiting—you see, I don't think there's a particular advantage to strictly limiting health to medical services either. I think there is a lot to be said for the Health ministry's intentions, and expressed intentions, to try to develop a more community health orientation or a more proactive preventive approach.

The problem is that just assuming then that everything that is occurring in community services should be dumped into the Health ministry to actually be structured and run through the Health ministry denies a whole wealth of experience that exists at the community level, actually, across the province that could usefully be brought together for a more preventive approach. I say we're denying the strength of our social support systems in turning it over administratively strictly to Health.

Mrs Sullivan: Thanks. I appreciate that clarification.
1430

Mr Jackson: Peter, I appreciate your brief, and especially the fact that you've given us in a very focused way a way of looking at this legislation in terms of its policy implications from an administrative point of view, and so I appreciate that.

But I'm rather shocked to hear from you that in fact there was no meaningful relationship between the social planning council here in Toronto or by extension elsewhere in the development process. Could you just briefly elaborate on that, or did I misinterpret what you said?

Mr Clutterbuck: I'd like to elaborate on that, because I also realize that it can be misconstrued in some ways. I realize that the district health councils were given

a very clear mandate out of the Ministry of Health more than a year ago around their responsibilities in long-term care and that they have a job to do. We recognize that the district health councils at the council level and among their staff have real valuable expertise to offer the community, we think primarily around health system, health care and health institutional planning.

Unfortunately, the mandate that was given to the district health councils did not, as far as we can determine, make any specific provision for them to include that other important social planning resource in our community, social planning organizations in a variety of forms across the province, as partners.

Mr Jackson: I'm sorry to interrupt you, but I'm trying to get to the nub of this, which is, as soon as you realized that, did you contact the government and ask, "Why were we omitted?" Or did you talk to somebody officially in long-term care? Is it fair to say that you weren't involved in the planning process, and now I'm trying to ask at what point did you contact the government and what were you told?

Mr Clutterbuck: District health councils will say that there was involvement in terms of consultations and in terms of trying to bring people around the table. There's a difference between there being involvement as one of the other players and involvement in a partnership for planning.

I want to make that distinction, in terms of recognition of our mandate, in terms of provision of adequate resources to fulfil our mandate in the same way the district health councils were, and we have made these concerns very explicit to both the Minister of Community and Social Services and the Minister of Health. In fact, we've been more explicit with the Minister of Community and Social Services in terms of our concerns about the withdrawal of the ministry from this whole policy area.

We saw it gradually happening since 1991 and we felt there's a whole area in which the ministry is abdication its policy responsibility, and feel that jointly the two ministries and the planning agents in the community could do a more effective job.

Mr Jackson: The situation that you're suggesting, the scenario that you paint, would indicate that with the dominance of the health model and the absolute power of the government in terms of appointing people to DHCs—and it's fair to say DHCs are institutional and professionally dominated. They are in my backyard, they are in most people's backyards and they're all political appointments.

I'm concerned about the MSAs now. You're by extension suggesting that the MSAs are going to reflect this as well, and several organizations that have come before this committee in just a day and a half have expressed the same fear.

According to the legislation, should that be more clearly set out as a solution? What you're suggesting simply is it will end up being that way, given the way the legislation's written. Would you like to see it in the regulations so that clients and social service support workers are represented more equitably?

Mr Clutterbuck: More equitably, actively and meaningfully involved in the process of designing and implementing multiservice agencies, if that's the route that's going to be. Our concern is that there is not an awful lot of specifics about MSAs except the powers in the actual bill, and that the actual design features, although there's been a lot of study and a number of options developed and discussed—the actual uniform design for the province probably doesn't exist. If we actually went on a community-by-community basis, you might get quite diverse and innovative forms of coordinating bodies at the local level. Some of them might actually choose or prefer to be more brokerage than actual direct service multiservice agencies.

We think that the government has heard from the community such a diverse range of possibilities that it can't actually create one uniform model for an MSA, and that's why it's not there. That suggests to me that if the government really were to allow the community to work effectively with its planning bodies, in fact we might get quite an enriched myriad of options that would create the policy framework by their common features, and that's not being allowed. Essentially, that's left up to the minister right now whether that can happen.

Mr Jackson: Finally, I just want to respond on your final point because, like many people, many legislators who are here before you today in this committee, we also toured the province and listened to presentations on phase 2 of long-term care, Bill 101. I recall very vividly in northern Ontario several communities where the planning council, and Lakehead strikes a chord in my memory, was intimately involved in the planning and integration. They were very, very excited that even though Bill 101 was institutional, they had already been developing models in accordance with the kind of vision you just referred to.

It's unfortunate we're not going to be televised when we are in northern Ontario in those communities, but I suspect there's going to be some very concerned people who've put four or five years of their life into planning towards one vision and now to have it disrupted by this legislation. But that's exactly your point, that what is unique to northern Ontario was being developed up there but doesn't fit the model of this legislation. I thank you on behalf of those other planning councils for putting that in perspective for this committee.

Ms Carter: Thank you for a very clear presentation. I certainly have a very high opinion of the social planning council in my own area of Peterborough and I certainly believe you should be having input.

We certainly do have the goal of integrating health and social services, and I think if you look at the basket of minimum services that the MSAs will have to offer, you can see that they are integrated services, so in that sense the integration is there. I would also just like to say that the government as a whole does have a prevention strategy to do everything we can to prevent people from becoming sick in the first place. Of course, as you know, that includes almost everything, things like better housing, providing more jobs, clean air, water and so on, so I think we're active on all those fronts.

Could you tell us what changes or additions you could make to those suggested services to provide what you feel is missing?

Mr Clutterbuck: I believe in my brief I actually looked on the four types of services as being a useful way, a helpful way in which to organize the range of services that are possible. I know the regulations do provide for additions within those four categories as well, which I think should always be left open, and that's a good thing. I don't have any particular difficulty, although I understand some other members of the community do, around what is identified in those four types of services. In fact, I think that's the hopeful sign, that there's some kind of integration potential here.

My concern more is with how a service system will materialize to have an adequate resource base in those four service areas over time. It's not so much with the definition of what should be available; it's more with how that might actually be realized.

For example, housing is in there and I have some difficulty in trying to imagine what greater expertise the Ministry of Health has in implementing social housing or housing programs than a lot of people in community support bodies across the province have with respect to providing supportive housing models for people with disabilities, for people with other forms of re-entry needs and that type of thing.

I think in fact the Ministry of Health has probably more limited expertise in that area, except for perhaps in mental health housing, and that we're leaving out a whole other knowledge base, an experience base that should be, through the Ministry of Community and Social Services, brought together.

Ms Carter: Of course, in practice, ministries do have to work together. You can never integrate everything.

Mr Clutterbuck: It's very important from our point of view that the Minister of Community and Social Services on this issue not be reported to or given progress reports on the development of long-term care, but that he and his officials and his networks in the community, which include ourselves, are actively involved in the planning process and in joint policy decision-making.

Ms Carter: You also made some comments about the membership of district health councils, and I think it is a concern that has certainly come up this morning at this committee, that there is a stipulation that there be consumer representation and we're not quite sure that has been adequately defined or that there are in fact sufficient numbers of genuine consumers.

There is an opportunity under the bill, to some extent, to refashion the district health councils and make sure that the membership is more representative. I wonder what suggestions or recommendations you would have about that, so that we could have better integrity in the health services.

1440

Mr Clutterbuck: I know that district health councils—at least the Metro one here—have tried to be very sensitive about trying to get consumer representation, and as far as I can tell, it has been successful. To its credit,

the Ministry of Health has issued a kind of direction and that's good.

At the end of the day, though, it's different to be representative of your community because you were chosen by your community, you were asked to serve by your community, versus being appointed by the government. The district health councils are still mandated agencies of the Ministry of Health and district health council members are accountable to the Minister of Health and that ministry.

We are trying to create a system here, I hope, a community service system that is accountable to the community as well in some important respects. In terms of meeting certain standards and certain levels of quality of service, it has to have some kind of accountability mechanism to the provincial government. But essentially, if it's really created by the community, it should be constituted by the community and it will then be accountable to the community.

Ms Carter: Don't you feel that's done under this legislation?

Mr Clutterbuck: I know that they have an amendment to expand the functions of district health councils. I didn't see any additional provisions besides the need to try to reflect the diversity of the community. In the end, it's still appointed by the minister and accountable to the minister.

Especially, it seems that district health councils are being set up for a longer-term, more significant role around broader integration of human services, and we would strongly suggest that if that's going to be the case, there needs to be some real look at its accountability relationships. More than just expanding its functions or having it make sure that it includes certain people by appointment, there has to be some real look at the structural nature of district health councils. We would recommend in fact that there's other experience in the community that can suggest how to create a more integrated planning mechanism.

Ms Carter: I wonder if we could ask for an expert opinion on the structure and to what extent it is community based.

The Vice-Chair: Do you want that done at this time?

Mr Wessenger: I would ask legal counsel to respond.

Ms Czukar: I would just say that there is the requirement in the amendment to the Ministry of Health Act that requires that the minister or cabinet, in making the appointments, ensure that the DHC is representative of its community.

There's a bit of a different concern here, however, regarding accountability. DHCs are advisory to the minister and they make recommendations to the Minister of Health, being appointed under the Ministry of Health Act. The delivery agencies, that is, the multiservice agencies, are accountable to the community through their memberships, which are elected by their membership from the community.

Mr Tony Martin (Sault Ste Marie): I think I understand where you're coming from in terms of making sure that the community in fact is in charge and signifi-

cantly involved in the decision-making—your comment about the district health council not really reflecting the community—although I think in my community anyway there's been a concerted effort over the last few years to try and have that group represent the community and represent consumers, put more consumers on that group.

I was also on the social planning council in Sault Ste Marie and I know that even in that organization—I don't know about yours. The question I have is, how is your social planning council chosen? I know that I was phoned up one day by somebody from the United Way who said, "Would you like to serve?" The social planning council in my community for all intents and purposes I think still is a body appointed by a certain élite in the community who pick and choose who they think would best serve. That still makes it somewhat problematic, and I guess the whole quest to find a real, true form of democracy. Even in the best of scenarios, where you have people elected from the community, you still only get those elected who choose to come.

I recognize that it's difficult. Even with the best of minds around this piece of legislation and trying to integrate things, I'm still not sure how you get there. Do you have any thoughts on that? I guess the direct question is, how is your social planning council chosen?

Mr Clutterbuck: We have an annual meeting and we have a nominating committee that searches for people every year. Every year we have an election. We never have strict acclamation. In other words, there are fewer vacancies than there are candidates running. So we make an assessment of our community and the nature of our community and who we should encourage to run as candidates, but we cannot guarantee who actually gets elected until the membership comes together and actually elects our board of directors.

The membership is pretty sensitive to what it needs, what its social planning council should be constituted of as well, so the membership tends to make wise choices about fairly representing the diversity of the community. We have older people, we have someone who can represent the youth constituency on our board, people from a business background, people from social services and health backgrounds.

In terms of our own council, our 40 councils across the province have actually developed a common statement of principles and values and the ways in which we work that I can make available to you; we've presented it to the two ministers. So there is some sense that we do have kind of a common set of characteristics and values and principles and ways of operating in our 40 social planning councils across the province.

Mr Martin: I'm led to believe that in fact is the process that is being proposed for local areas re the governing body of these MSAs, so I think in terms of—

Mr Clutterbuck: My recollection is that the composition of the board is left to the regulations. I didn't see that specified in the bill itself.

Mr Martin: Again, your sharing of how you do it here and how effective that is will probably be very helpful to us as we try to put those regulations together

in order to make sure that the governing bodies of these MSAs are in fact representative of the community within which they are located.

The Vice-Chair: Thank you for your presentation.

Mr Clutterbuck: Thanks very much.

Mr Tony Rizzo (Oakwood): Thank you for the opportunity to place a question, Mr Chair.

The Vice-Chair: Sorry, we've run out of time. I've had two speakers. That was my mistake, Mr Rizzo. I apologize.

BAYCREST CENTRE FOR GERIATRIC CARE

The Vice-Chair: The next presentation will be by a representative of Baycrest Centre. Good afternoon and welcome to the committee. Please proceed with your presentation.

Dr Moshe Greengarten: My name is Moshe Greengarten. I'm vice-president of public and community affairs at Baycrest Centre for Geriatric Care in Toronto.

Baycrest Centre for Geriatric Care wholeheartedly endorses the major thrust of Bill 173; that is, the creation of multiservice agencies in Ontario. If there is only one message we leave you with today, it is this: We believe that multiservice agencies will help simplify access to services for older adults and their families. If properly funded, they will yield positive results in supporting older adults in their own homes and communities.

There will no doubt be growing pains for all stakeholders as multiservice agencies are formed, and we must all do our part to ease the transition. Nevertheless, we believe that in the long run, the residents of Ontario will benefit from the development of these new organizational entities.

As members of the committee are probably aware, Baycrest has endorsed the formation of ethnospecific multiservice agencies in addition to geographically based agencies. We believe that such ethnospecific agencies, along with specialized satellite services, are essential to meeting the service requirements of ethnic seniors.

While the legislation is directed primarily at the formation of geographic agencies, we believe that it does not preclude other approaches. Thus, subsection 11(4) states, "The minister may designate more than one multiservice agency for the same geographic area or part of a geographic area." We support this section, which we interpret to allow for the possible future formation of ethnospecific services which might overlap with geographically based services.

1450

We were also gratified that the Minister of Health, in her letter to the Metropolitan Toronto District Health Council, stated: "As planning consortia undertake their work they will have to consider how MSA governance, structure and policies will reflect ethnocultural communities. In addition, the DHC will have to ensure that ethnocultural communities without a geographic base are well served by the new system. I understand it is anticipated that planning consortia will identify themselves as 'leads' for various ethnocultural communities. This would appear to be a very practical approach."

Other sections of Bill 173 supporting the long-term care reform principle of "promoting racial equity and cultural sensitivity" include paragraph 3 of the proposed bill of rights and the requirements for board composition. To further strengthen this principle, two amendments are proposed.

First, it is recommended that subsection 56(1) be amended to allow for regulations concerning the establishment of MSA satellite offices, as follows. We propose that the following subsection be added: "governing the establishment of satellite offices in order to address cultural, ethnic, spiritual, linguistic and regional differences."

Second, it is recommended that section 20, dealing with the development of service plans, be amended to address the specific needs of ethnic seniors, as follows. Add clause (d): "for each person who is determined to be eligible, develop a plan of service which takes account of the person's preferences based on ethnic, spiritual, linguistic, familial and cultural factors."

Section 25 sets out a framework for charging for certain services provided through multiservice agencies. We agree that there should be no charges for professional or personal support services. However, while individuals should not be denied homemaking and community support services based on ability to pay, we believe the amounts of charges for these services should not be regulated. Rather, additional funds generated through higher fees could be used for activities such as service enhancements, the development of new services, purchase of equipment, staff training or research activities.

The following amendment is recommended. We recommend deletion of the phrases in paragraph 56(1)21 "regulating the amounts of the fees required or permitted to be charged, including" and "required or permitted." As amended, the paragraph reads as follows: "requiring or permitting approved agencies to charge fees to persons receiving community support services or homemaking services under specified circumstances and prescribing the manner of determining the amounts of the fees to be charged."

On a further subject, Baycrest objects to subsection 58(3), which gives the minister power to "take control of, operate and manage an approved charitable home for the aged." We believe the Charitable Institutions Act currently incorporates sufficient safeguards for residents of charitable homes for the aged and the general public. These safeguards include the requirement for service agreements between charitable homes for the aged and the crown; the power of the ministry to withhold or reduce payments if the charitable home for the aged breaches its service agreement; fines of \$5,000 to \$10,000 for certain offences; sweeping, and some would say punitive, inspection procedures; and the power of the minister to suspend or revoke approval. Under these circumstances, the subsection in question can only serve to alienate the volunteer boards of charitable homes.

The following amendment is therefore recommended: that subsection 58(3), consisting of a proposed section 11.1 of the Charitable Institutions Act, be deleted.

Mr Jim Wilson: Thank you, Doctor, for once again

appearing before the social development committee. I guess because you just proposed it, I'm a little confused on what you're suggesting with respect to fees and the regulatory powers in paragraph 21 of section 56. I guess I need you to throw that by me again. As I understand what you've just requested, you'd like it left up to the MSAs to set the fees, strictly. Would that not lead, though, to different fees in different parts of the province for some of those services?

Dr Greengarten: Yes, that is correct. We would recommend that, and we agree it could result in different fees in different parts of the province, as we have today.

Mr Jim Wilson: Can you give us a further justification of why that should be done?

Dr Greengarten: We would argue that a province-wide fee does not take account of regional differences, of differences in various communities to pay for services, of organizations' abilities to be creative in generating revenues. I think it sets limits on organizations, on voluntary organizations in particular, which aren't required.

Mr Jim Wilson: Do you have any idea how the residents of Baycrest would feel about your proposal?

Dr Greengarten: We're not talking about the residents of Baycrest; we're talking about the clients of Baycrest who live in the community.

Mr Jim Wilson: I'm sorry, yes.

Dr Greengarten: As you heard earlier from a group representing senior citizens, I think if you ask organizations representing senior citizens, they have a responsibility to reflect the view that there shouldn't be any user fees at all. I think we're living in a society where that's becoming increasingly difficult to sustain as public policy and I think individual senior citizens and their families recognize that they don't expect the full burden to be carried by the public purse.

Mr Jim Wilson: It's almost a moot point anyway. There are millions of dollars worth of user fees in the system now.

Dr Greengarten: One of the difficulties that we face is that the imposition of limits on fees, we believe, will reduce the existing funding level available to us and to other agencies, that we will lose revenues as a result of the imposition of fee limits which will not be supplemented through additional government support. That will have an impact on our clients which is significant.

Mr Jim Wilson: Could the converse not also occur, though? If the government discovers you're bringing in all kinds of money through fees that are above the provincial average, for example, it may roll back what little support it's giving you now anyway.

Dr Greengarten: It's possible that could occur, but as we've recommended in our paper, there are many areas that additional fee revenues could support that could enhance services and would be reasonable areas for support, including research, purchase of equipment etc, which would not have to be recovered by government.

Mr Jim Wilson: So the bottom line is there are going to be fees, obviously, that's here in the act, but there should be some local autonomy with respect to the levels.

Dr Greengarten: That's correct.

Mr Jim Wilson: Could you explain to me what the implications of the changes to the charitable homes for the aged are once again?

Dr Greengarten: One of the paragraphs of Bill 173 deals with certain new parts of the Charitable Institutions Act dealing with charitable homes for the aged. One of these sections, subsection 58(3), gives the minister power to "take control of, operate and manage an approved charitable home for the aged," under certain circumstances. We believe that power is not necessary, that there are sufficient powers in the Charitable Institutions Act and that this additional section can only serve to alienate volunteer boards of directors.

Mr Jim Wilson: I'm glad you brought it up. Mr Chairman, with your indulgence, perhaps I could ask the parliamentary assistant why that section is in there. It seems to me when you read it—I read it again last night—it's a fairly draconian section. It sounds that with fairly dubious reasons the minister can come in and take over the operation of a charitable home. Also in your answer to that I need a clarification, because the wording of the act, as proposed here, is that there has to be some approval from the board of the charitable home at some point also. I was a little confused as to what the mechanism is, exactly how the minister takes over the operation.

Mr Wessenger: First of all, this power does presently exist under the act relating to the Ministry of Community and Social Services, so the takeover part already exists. We're not creating a new power under this act; we're just putting it under the provisions of the Ministry of Health, as distinct from the Ministry of Community and Social Services.

Perhaps I'll ask legal counsel who may wish to add something to the comments, but I think we can understand a situation if you had a charitable home, for instance, that was in an insolvent position or was unable to deliver the service, you'd want to make sure that service was continued so the residents would not be left without service. I don't know whether legal counsel can add anything else to that or not.

1500

Ms Czukar: I would just say that it does exist currently under the Ministry of Community and Social Services Act and since these institutions are now under the administration of the Ministry of Health, we needed to amend the act to make it clear that this takeover power still exists in relation to these homes and the provision—I think you must be referring to 11.1(1)(a), which talks about the minister taking control of, managing and operating a home if the home consents, and that's a situation where the home might, for some reason, not be able to operate and say, "Minister, would you take control?" and the minister wouldn't have the power to do that unless it were given. So that's why that's there.

The other conditions under which the minister can take control of and operate a home are where the physical state of the home or the manner of operation is causing or likely to cause harm to people, and obviously that's a situation where the ministry might have to act very

quickly, rather than just revoking an approval or suspending an approval. In the meantime, the ministry might need to ensure that people are going to be looked after.

I would also point out that other subsections of that section require a hearing to be held as soon as possible after any of those of powers are exercised.

Mr Jim Wilson: I guess the reason it raises suspicions for me in this act is, why wasn't it done under Bill 101? To have it suddenly appear here just baffles me.

Ms Czukar: The transfer of administration from Comsoc to Health hadn't occurred at the time Bill 101 was being discussed.

Mr Malkowski: Thank you for your presentation. I know Baycrest has an excellent reputation for volunteerism and for local fund-raising, and one way that MSAs can build on this tradition is perhaps to have programs continue to have their separate identities and yet, at the same time, they could share common local community boards. What other ways can you see other traditions being reflected?

Dr Greengarten: I'm not sure that I understand the question completely. As we see it, the proposal for multiservice agencies will allow for volunteer boards of communities. They will allow for volunteer governance and we support this approach.

You may be referring to our comments about the needs of serving ethnic communities, and in that respect we believe that one approach to doing this is by allowing for ethnospecific multiservice agencies which will serve larger ethnic communities. Another approach is to allow for ethnospecific satellites which may be part of geographic multiservice agencies. But the key here is to foster within communities, regardless whether they are geographic, ethnic or perhaps based on some other basis, a sense of ownership and a sense of pride in their institutions.

Mr Martin: I just want to say, first off, that given the pattern so far, your stance, being a provider, is a bit of an anomaly. I don't know if that's going to set a trend for the rest of the hearings, but your support of this bill, being who you are, is for us on this side actually rather refreshing, and we thank you for that.

But I do have some questions, given that you are a provider, around how you've come to be able to support the concept of MSA, and given that in the regulations, or proposed regulations, there will be a 20% window for providers in this, how you see yourselves fitting in and continuing to offer the services that, as Mr Malkowski has referenced, you obviously deliver very well?

Dr Greengarten: By whatever name you call it, a multiservice agency or some other name, we have been endeavouring to develop what we call a continuum of services to our community for many, many years, many decades. We believe that the multiservice agency concept comes closest, in what we've seen, to approaching the kind of spectrum of services available in one place for seniors and their families, through one contact, is as close to that model that we've been trying to develop as anything we've seen, so that's why we support it.

Where exactly our organization will fit in is a question

that will have to be determined through community consultations and community planning. We will continue to exist in some forms providing some kinds of services regardless of what happens with multiservice agencies. We hope we will be part of the multiservice agency framework within our geographic area, but regardless, just in principle we believe that it is a good way, and the best way so far, of providing service, of organizing service so it's understandable to the consumer.

Sure, from the provider perspective it's going to create problems. We will have our own vested interests for different reasons in being supportive of or against multiservice agencies. But the bottom line is that we, particularly our boards, our volunteers, are in this area to ensure that consumers in our communities receive the best possible service, and in that context, and trying to wear that hat, that objective hat, this is a positive step, in our view.

Mr Martin: Do I have some more time?

The Vice-Chair: For a very short question, one additional question.

Mr Martin: A very short question: There's the question again from providers when they come that somehow in this move to an MSA system they will lose the essence of who they are or they will not be able to transfer what somebody referred to as ethos, as reason for being, a spiritual dimension that often flows through. How are you going to deal with that?

Dr Greengarten: We're a large organization, and I'm not sure we're in the same situation as many of the organizations that are coming before you.

But on the issue of ethos, of a sense of an organization, over the course of the history of the voluntary sector in this province, voluntary organizations come and go. Volunteer organizations change their missions to reflect changing circumstances. An organization that may have served, let's say, certain health needs many decades ago didn't have to do that when hospitals came along and medicare came along, so their mission could change or they could go out of business as a volunteer organization. Many of them changed their missions, and that has gone on. So in taking the long view, organizations have changed, their missions have changed, and that is a process that will continue to go on whether there is Bill 173 or there isn't Bill 173, because circumstances will change in our larger communities.

I would hope that organizations, and particularly the voluntary boards of organizations, will try to see the larger good that could come out of this, that they can continue to maintain their sense of purpose and their sense of mission, either through a new form of organization, an MSA, or in developing new missions and providing new services that will be very worthwhile, I'm sure.

Mrs Sullivan: I'm interested in the amendments that you've proposed, and we are certainly supportive in particular of the amendments 1, 2 and 3 that you've put on the table. I think in particular amendments 1 and 2 are interesting, because they address some of the issues that have been very much on people's minds before the

hearings, and in fact what I see them doing, these amendments, is enabling a far more sensitive surround to the MSA bureaucratic structure, frankly.

I recall in Bill 101 Dr Bob Rumball appeared before our committee, and I asked him at the time if he felt that the Bob Rumball Centre for the Deaf might be bidding to become an MSA on its own for a particular linguistic cultural community. He said at the time that he thought that might be a very good idea and it was something that was certainly on their mind.

Saint Elizabeth's and the Catholic agencies have appeared before the committee indicating that they will go out of business with this MSA bill. You say that Baycrest is in a different situation. If you are not named as an MSA, I suspect that you may well go out of business too. I think these amendments enable you to stay in business and continue to provide service. In fact, you become not only a regional deliverer of service but one where the integrated services in the history of your own organization and its own development will be recognized. I'd like you to comment on that.

1510

Dr Greengarten: We are proposing these amendments because we believe that they will help to support the approach we've taken, the tradition of serving the Jewish community in the greater Toronto area. We believe that they, if approved, would help to put into place a framework which will not only help us but other community-based organizations be effective partners in the development of the multiservice agency framework. So that is why we have put them forward; you're quite right.

Mrs Sullivan: In the absence of this, particularly amendments 1 and 2, do you see yourself ceasing to function as part of the public component of long-term care delivery?

Dr Greengarten: It's hard for me to speculate on that. I think, whether they're passed or not, we will work tirelessly to try to ensure that our community is served.

Mrs Sullivan: But in the absence of this kind of an amendment, basically your services would then have to be directed to the fee-paying client—

Dr Greengarten: I don't believe that's the case.

Mrs Sullivan: —unless they were purchased, in that 20% component, by an MSA.

Dr Greengarten: I'm not sure that I can respond to that question.

Mrs Sullivan: I think you'll find that's what the scenario is.

ASSOCIATION OF ALLIED HEALTH PROFESSIONALS: ONTARIO

The Vice-Chair: The next presentation will be made by a representative of the Association of Allied Health Professionals. Welcome to the committee. Please introduce yourself for Hansard and proceed with your presentation.

Ms Catherine Bowman: My name is Catherine Bowman, and I'm the executive director of the Association of Allied Health Professionals, or AAHPO. We are

a union which represents over 1,400 health professionals across Ontario. Approximately three quarters of our members are in hospitals; the remaining one quarter are employed by public health units or boards of health. It is this latter group of employees that will be most directly affected by Bill 173.

In health units, we represent 11 out of the total 38 home care programs across the province, or approximately 30%. In our brief, we've given you a list of those programs. They're located primarily outside of the large urban centres, with the exception of the Ottawa-Carleton region.

The main classifications which we represent which will be affected by the bill are: case managers, nutritionists and dietitians, occupational therapists, physiotherapists, social workers and speech pathologists.

We generally support the introduction of this legislation that will make MSAs a reality. There has been and continues to be a great deal of uncertainty in the community about MSAs and the implementation of long-term care reform, and generally we agree with the five stated objectives of Bill 173, namely: the one-stop access; improved community-based service; consumer-focused system; improved and consistent accountability; and local, community-controlled planning.

However, we do have some concerns about how these objectives will be met through the legislation, and we believe that there are a couple of important issues which are not dealt with in the bill. It's on those points that our submission is concentrating. The main points which we are covering in the bill have to do with: better definitions for the provision of professional services; additional criteria for the approval of agencies; the need for fairer consideration of boards of health as designated MSAs; the need to further restrict the purchase of services, and included in this, the deletion of two of the three exceptions on purchase of services. We believe there needs to be some clarification in the appeal procedure, as well as a qualification on the repeal of paragraph 5, section 5 of the Health Protection and Promotion Act. We'd also like to talk a little bit about district health councils and the need for protection for existing employees in community-based agencies. Because of the brevity of the time, I'm not going to go through my brief in detail. I'll leave that to you to peruse at your leisure, and I will just highlight some of those points.

One of our main concerns is the assumption that everyone is making, that alternative, presumably lower-cost, workers can be trained to provide professional services. This we believe moves against the direction in which the government has been moving through the Regulated Health Professions Act, and although the compendium that accompanied the bill talks about that act and recognizes that there are certain restricted tasks, there is no reference to this in the bill. We believe that's an oversight, that there should be some recognition that in the provision of professional services there should be some minimum qualifications that should be met.

Although we recognize that professionals may on occasion train family members or may train lesser qualified people such as homemakers to provide certain

specific treatments, we believe that should always be done on an individual, case-by-case basis and then it's not something that people can be trained in a matter of weeks to be a generic worker to do everything for everyone in the home. So we have some serious concerns regarding that and believe that the bill should be amended to provide similar provisions to that in other acts. We recognize that there is provision in the act for regulations which may prescribe qualifications or requirements for service providers but we would like to see that strengthened.

In terms of the approval of the agencies, we have some concern that the minister will be looking at the financial capabilities, the good intentions and suitable premises of agencies, but there's nothing to do with the human resources, and we believe that the success of an MSA is dependent on the quality of the staff who will be delivering those services and that's something that should be considered in terms of the approval process. I think there's going to be a tendency for people to look at the financial bottom line and therefore for employers to try and shave costs by using less qualified people. We believe that is not in the best interests of consumers and we believe that should be considered in the approval process.

As far as boards of health are concerned, the bill provides right now that boards of health or municipalities should only be considered after all other agencies. We believe that this should be deleted and that they should be allowed to compete along with other agencies. I believe that the compendium states that this is to ensure that the composition of the MSA meets the requirements of the act, yet it ignores the many years of valuable experience both administratively and in the provision of services, and these people should not automatically be placed at the bottom of the list. Just as there are exemptions elsewhere in the act, recognizing that it may take four years to get up to the proposed limit on purchased services, there could also be an exemption for boards or municipalities in order to give them time to alter the composition of their boards to come in line with the direction desired by the government. This would be more practical and less expensive than requiring entire new agencies to be set up.

In terms of the purchase of services, the Implementation Framework, June 1993 document stated that the purchase of services would be the exception for MSAs, not the standard. It also stated that there would be a 10% maximum limit for purchases from commercial, for-profit agencies. In Bill 173, the government is suggesting that agencies be allowed to purchase up to 20% of their services and it goes on to provide some exceptions to this which in fact means that agencies could purchase significantly more than that 20%.

In addition, there's no mention of a restriction on purchasing services from commercial agencies nor even a stated preference for not-for-profit agencies. We believe that this is a backward step. We have some very serious concerns about the proliferation of private, for-profit health care and also the implications that contracting out have for job security for workers. We think that contracting out can compromise the quality of service, especially

when we're talking professional services. In many cases, several professionals may be seeing the same patient at the same time and it's imperative that they coordinate their treatment plans, and this is best done when people are employees of the same organization. Contracting out just increases the already difficult communication problems. Also, agencies do not have the same control over the quality and standards of service that are being provided.

The other concern we have with respect to purchased services is that there's no requirement that they be purchased from approved agencies. The bill just refers to service providers. Again, we believe that if they are going to be purchased—and we believe they should be much more strictly limited in the bill—then those purchases should only be from approved agencies.

1520

The two exceptions that we have problems with are the ability for agencies to purchase services to cover short-term absences and to purchase services from individuals. Neither of those are to be counted towards the 20%, and we believe that that undermines the purpose for having a limit in the first place.

As far as covering short-term absences, it's common practice in hospitals and other health care agencies to employ employees on an as-needed basis. This could easily be done by MSAs and it would ensure that the relief staff are fully oriented to MSA procedures and meet the qualifications and standards of service required. It would also be less expensive. The same is true in terms of purchases from individuals. Again, we believe those exceptions should be deleted from the bill.

We have some concerns, in terms of the appeal process, that this will create an unnecessary, time-consuming and bureaucratic process. We agree that people should be able to challenge decisions, but we have some real concerns that professional judgements are going to be questioned as well and the impact that this will have on professionals being reluctant to exercise that judgement in order to avoid the threat of a lengthy appeal. We feel that there needs to be some clarification in the appeal process with respect to professional decisions regarding whether treatment is or is not warranted or the alteration of treatment plans and that perhaps an ombudsperson would be a better route to follow than a full appeal board in appealing these kinds of decisions.

With respect to paragraph 5 of section 5 of the Health Protection and Promotion Act, this may be a technicality but we're concerned. This requirement in the act requires boards of health to ensure the provision of home care services that are insured services, and our concern is that there may inadvertently be a gap created if this bill is passed, there's a repeal, and there are not MSAs up and running in the community to take over the home care services. So we believe that that should be qualified and only applicable to boards of health where an MSA has taken over the provision of home care services.

As far as district health councils are concerned, we support the premise behind them, but we have some serious concerns about the current composition of DHCs. Along with other unions, we believe that unions and

front-line health care workers are very poorly represented at the present time and there needs to be much broader representation on DHCs.

We do support the requirement for providers of health services to provide the minister and DHC with plans and other information upon request. We believe that this merely brings the community in line with the hospital operating plan process, which has been in place since November 1991 and which has led to a greater involvement of both internal and external stakeholders.

In terms of looking at the appointment process to DHCs, we believe that it should not only reflect the diversity of the population, but it should also reflect the diversity of stakeholders in the health care system, and we believe that each union should automatically be entitled to sit on, at the very least, DHC subcommittees where they are representing health care workers in an area and that labour should be guaranteed a number of appointees on each DHC.

What is missing from the bill, and we believe that this is a very glaring omission, is job security for existing employees working in agencies in the community. Throughout the consultation process, fair treatment and job security for employees was promised, and the bill is entirely silent on this.

We believe that there should be no question that, as services are moved from an existing agency to an MSA, the employees currently employed in providing those services should be guaranteed continued employment and that they should suffer no loss of salary or benefits. We believe that it's very humiliating to have to apply for your own job that you've been performing for years, and we don't think the MSAs should be able to take advantage of a technical change in employers to replace existing employees. The unions have been requesting of the government a comprehensive, enforceable provincial employment security agreement for the entire health care system, but since we have not been successful in achieving that, we believe that it's crucial that Bill 173 include provisions which provide this type of protection to employees who are going to be affected by the long-term care reform.

The final point we wanted to make is not really specific to Bill 173 in that there are no real amendments that we can suggest for it, but there is an underlying assumption that this legislation is dealing primarily with the elderly, adults with physical disabilities and people who are trying to remain independent in the community. But the reality today is that home care services very much have to do with acute care and rehabilitative services and the provision of paediatric services to students in schools. We believe that the needs of these people are sometimes very different and that, unlike the assumption that's made that institutional care is a last resort, for these people it may be the preferred resort, and what we are concerned about is that the system must be flexible enough to accommodate that.

Really what we're talking about is where the MSAs fit in with the continuum of health care in the community. We're seeing more and more demands being placed on the home care programs as hospitals are discharging

patients earlier and earlier and sicker and sicker, so we believe this is a very serious concern that the government has to take a look at. Otherwise we are going to see early discharge patients drawing on resources that have been promised to the elderly and adults with disabilities to allow them to cope more independently in the community.

I believe that covers the main points. We think it's very important that there be a framework in place as quickly as possible to provide the kind of protection to both the public and the employees working in the system than has been promised through the consultation process.

Mr Jackson: Thank you for your presentation. There have been a lot of presentations so far that speculate about the impact of this, and I think you've come close to expressing some concern in your final comments about the impact of early discharge from hospitals. That has not really been discussed. The seniors have indicated that type of citizen is being discharged far too early and in much sicker condition, I think was the way they referred to it.

If you take one large step back from Bill 173 and put it in the context of all the things that are happening to ratchet down health care at the hospital level, and the lack of bed growth for chronic care across all levels in all sectors, there are reductions. Chronic care hospitals, regular hospitals, nursing homes, homes for the aged, all of them are in reduction mode.

Some have gone so far as to suggest, and I think you almost did, that the MSAs will be predominated by being the conduit or the discharge for people who are in hospitals—in fact there'll be a shift of emphasis from those persons who are truly in a case of community need, where they're not necessarily hospitalized but their condition is degenerating to a point where they need intermittent services—but that in fact the institutional-based protocols that are calling upon the MSAs will rise to predominance. Some of them have even gone so far as to suggest, if you are discharged from a hospital you get the services, but if you're sitting out in the community in a lessening state, then you're just going to have to wait months, as is the case now, for appropriate services to be put in place.

Is that part of your concern, and are you seeing evidence of it as we're starting to see evidence of it from when we talk to home care, when they say a disproportionate growing number of our cohort of services are people being discharged from hospital and not necessarily people who are in need of the services simply because they're frail and elderly and unable to get into any form of institutional care?

Ms Bowman: Certainly we are concerned that our members are seeing more problems with people who are being discharged from hospitals prematurely. A lot of the difficulty comes from inadequate discharge planning that the services may have been able to have put in place if they were kept in hospital just a little bit longer to allow that kind of coordination to take place. What's happening instead is they're being discharged, sent home, and it's a crisis situation that people are having to deal with in many instances.

We do have some concerns but nothing we can document. We're attempting to try and gather some documentation on the kind of anecdotal evidence that we have. So, yes, we are concerned about a sort of double standard being created. As patients are discharged from hospitals into the community, it's the premature discharges that we are concerned about. Some people are ready to go home and are quite able to cope with just some assistance or some professional services with homemaking and personal support services on a short-term basis.

It's where the MSAs fit into the continuum of health care that we are concerned about. They are not the be-all and end-all. There will always be a need for facility care and there will always be a need for individuals, especially those who are living on their own independently who have no family on which to depend. They are our concern.

1530

Mr Jackson: I recognize your comments about the labour representation and worker representation on the MSA boards, and I think that's clear and understandable. I want to set that aside, though, and talk about the institutional and professional imbalance which is being referred to—it has come up in three briefs today and about four yesterday—to the extent that just as hospitals have a significant impact on district health council decisions, again hospitals will have a significant impact, through composition and allegiance, if they're involved with the MSAs.

Certainly, if you look at where people are being discharged into institutional care, there is primacy given to patients who leave a hospital to go into an institution rather than family in crisis, where mom can no longer take care of dad so they're on a long waiting list to get into an institution. I see the influences of hospitals through discharging into institutional care and my fear is that we may see something similar.

Ms Bowman: Hopefully, the placement coordination services will help to alleviate that problem, whereby the admissions into institutions will all be funnelled through the placement coordination services.

Mr Jackson: But who runs placement coordination services?

Ms Bowman: At the current time a lot of them are located in home care programs, and it's my understanding that they will transfer with those home care programs to the MSAs. That's not the case in all instances but, as I said, our concern is where the MSAs fit into the system as a whole, and this has to be looked at from a system-wide perspective and not just a community care perspective as far as the elderly and disabled adults are concerned.

Mr Martin: I want to thank you for your support of this legislation and your encouragement, and certainly understand some of your questions and concerns. That really is what these hearings are about, so that we can fine-tune and find ways of making it more responsive. Certainly I agree with your recommendation that we need to somehow find some flexibility in this, but that will

very much, from my perspective, depend as well on reasonable people out there applying some of these things. We can only set so many parameters and frameworks around things and then we expect that reasonable people out in the field will make intelligent, reasonable decisions. When you lay out a scenario where somebody is sent home from hospital with two broken arms, I ask myself who would do that.

Ms Bowman: It was a case that was relayed to me as early as two days ago.

Mr Martin: Yes, and I don't know how you put in legislation things that will stop that kind of business from happening.

Ms Bowman: Having discharge planning is how you stop that from happening. Before people are sent home, if somebody gets to talk to them and identify what needs they have and to make sure that they are not going home alone.

Mr Martin: Anyway, my questions were around your wanting further protection for the people already working in the field. We've certainly heard so far, in the two days that we've had hearings, that same concern raised by some folks—actually, this may be a bit strong, but an accusation that the government is in fact intending to employ the more professional sort of unionized organized people who are in the field now as opposed to the myriad of others who are out there who will be affected by this legislation one way or another. I mean, there's real fear.

Does your concern for the workers in the field now go beyond the organized unionized groups that are there now or is—

Ms Bowman: Certainly, because I believe that the organized unionized groups have some formal protections through their successor rights under the Labour Relations Act, and we will be pursuing those rights to the best of our ability. But to a large extent the community agencies are not organized and those people are very susceptible. They don't have any recourse to fall back on to insist that they get to keep their jobs, in essence, that they are performing now when those services or jobs are being transferred. We believe the people should be attached to the jobs and, if the jobs move, the people should move.

Certainly there will be questions to be answered in terms of bargaining rights and organizing and all the rest of it, but there is a large group of unorganized workers out there who are very vulnerable as well and require the protection in the act to ensure they get to keep their jobs.

Mr Martin: How do we sort out, then, in terms of saving everybody's job, some of the philosophic differences that are now in organizations? Like this morning, we had a woman present who was very strong in her feeling that it isn't necessarily the most educated person who's going to do the better job in terms of home care outreach; it will be somebody who has that sort of heart, you know, who really wants to do it, who understands. How do you sort all that out?

Ms Bowman: I think it depends on the job that you're talking about. I feel quite strongly that if you're going to perform physiotherapy services or occupational therapy services, then you'd better be a qualified, regis-

tered occupational therapist or physiotherapist. I don't want somebody who isn't qualified, who isn't registered with the college, performing treatment on myself, members of my family, members of the community.

There are lots of other jobs being provided in the community that may not require that level of expertise, may not require that high level of professionalism, and that, yes, are being performed right now. I don't think the people who are performing those jobs should be thrown out of their jobs and replaced by someone else. There has to be some compassion and some flexibility in the system.

What we were looking for is something in the bill that would create an obligation on the part of MSAs to absorb not only the services and the jobs but the people attached to them, and then sort it out after the fact. But people have to have some sense of security and some certainty, and right now there is very little certainty out there in terms of what is going to happen to people when these MSAs are created. So I think there is a real need for the bill to address that.

Mr Martin: Just one other piece, if I have some time: On the inclusion of your group on the DHCs and on the governing boards of MSAs, it becomes quite cumbersome if you try to include everybody. I know from just watching in my own community efforts to try to include consumers. As soon as you get more consumers than you have providers, you have a problem on your hands because the balance of power is shifting and all of that.

Any thoughts on how logistically we might include some of the folks that you're recommending be on those organizations at this point and still maintain that balance and still have this be consumer-driven?

Ms Bowman: You have to recognize that union members are consumers as well, and the purpose of a union is to represent front-line workers, so I think that representation on DHCs and MSAs should be drawn from unions. I know there's been a real difficulty on the part of the government and some other organizations in recognizing that, but if people want a voice and they want to be represented, they join a union. If they don't, then they allow the employer to speak on their behalf.

In looking at the composition of these various organizations, I believe that if you have a cross-section of unions, you'll have a cross-section of front-line workers. It's important that you have front-line workers who are involved in the delivery of these services, and not just your administrative types or your management types. That's where you will get improved quality in the decision-making.

I don't think there's a need to have to look to unorganized workers to sit on here. Yes, from a consumer point of view, but from a provider point of view, we believe the representation should be drawn from organized workers and from unions. That's their purpose. They are there to speak on behalf of all workers, and I think have done a very good job when they are sitting on these committees.

The difficulty is there are not enough of them, and there has been a perceived conflict of interest in having

union members sitting on DHCs, but there's no conflict having hospital administrators or doctors, who are driving the system, sitting on DHCs. So that's a double standard as far as we're concerned.

1540

Mr McGuinty: Thank you very much for your presentation. Your presentation here constitutes a very effective—what would I call it?—expression of advocacy on behalf of the people you represent, and I'm personally a little bit disappointed that it did not make greater reference to the broader public interest and the consumer, the end user.

Your presentation is a bit of an anomaly in the sense that you are actually asking that the government reconsider its 20% cap on outside services and you're suggesting that it in fact be reduced. You're also saying if the government is going to allow MSAs to purchase services, that preference should be given to not-for-profits.

If I'm a consumer, if I'm a senior, how would those amendments help me? I can see very well how they will help you and the group you represent, but how do they help me as a senior?

Ms Bowman: I'm sorry that you've interpreted this submission as being entirely in our self-interest. Because of the time allotted I necessarily concentrated on issues that were of direct concern to our organization and our members, but in so doing I do believe it will lead to a better system.

In terms of the not-for-profit issue, we believe that for-profit drains money out of the health care system. This is taxpayers' money that we're talking about, and we believe it should be used for the provision of services. We have some real concerns about two-tier systems and all the rest of it. I think you can get a high-quality service from a not-for-profit agency.

Mr McGuinty: Correct me if I'm wrong, but I thought the money that the province pays to for-profits for services is exactly the same as we're paying to not-for-profits.

Ms Bowman: That's true. I guess the question is that the profit has to come from somewhere and I'm not convinced that the profit comes simply from efficiencies. I think that's perhaps a fundamental concern, as well as the impact of the people who are delivering those services. It's a fundamental philosophical—we do not believe in for-profit health care. It was our understanding that this government, at the beginning of the consultation process, also had a preference for not-for-profit health care, so we were disappointed not to see that show up in the bill.

Mrs Sullivan: I'm interested in a technical proposal that you've made in your brief. I haven't quite finished going through the entire thing, but it's with respect to section 59, which would repeal the requirements of the boards of health to ensure the provision of home care services that are insured services under the Health Insurance Act.

You've made what I think is a valid point, indicating that until an MSA is up and functioning and fully operational and the home care program working under-

neath it, it doesn't make sense to repeal that provision. I wonder if the parliamentary assistant would comment about what the intentions of the government would be with respect to proclaiming that section.

Mr Wessinger: I'm going to ask legal counsel to comment on this issue.

Ms Czukar: The provision for approved agencies in the bill is for exactly that reason, to allow existing programs to become approved and to continue to operate until such time as MSAs are designated and those programs would be operated by MSAs.

Mrs Sullivan: But in this case the repeal is in advance of the operation of similar programs by an MSA.

Ms Czukar: That's correct, but the agencies that currently operate the home care programs can become approved agencies under Bill 173 and can perform all the things that they're doing now as an approved agency under the bill. The repeal of this section really is just to remove the statutory obligation on boards of health to be operating home care services when that's going to be done by approved agencies and MSAs. It's not fair to them to require them to continue to provide this.

Mrs Sullivan: All right, then let's just walk through this in a step-by-step way. Now, in many communities, home care is provided by the boards of health in those communities. Is there a guarantee that the minister will make every single board of health that currently operates a home care program an approved agency?

Ms Czukar: There's no guarantee in the act, but the minister is going to need to do that to ensure that the province continues to be covered by home care agencies in every area where they currently exist.

Mrs Sullivan: We may better have a little look at this part, just to be certain that if the bill comes into force and the MSA is supposed to be organized in a community, with a board etc etc etc, and the minister hasn't designated the board of health as an approved agency and this particular section is repealed, then the board of health could say, "Sorry, we're out of home care" before the MSA is up and running. Listen, I don't trust anything around here.

Mr Wessinger: I think that's theoretically possible, but the normal process would be that the approval would be simultaneous with—

Mrs Sullivan: The normal process?

Mr Wessinger: The policy adviser might be able to add something.

Mr Geoff Quirt: Just by way of clarification, in seven or eight places in Ontario the public health board has nothing to do with the delivery of the home care program—

Mrs Sullivan: I understand that. I'm only asking about this particular section.

Mr Quirt: —and as has been pointed out, the minister would be obligated to approve home care programs, the public health unit or the regional municipality as an approved agency to continue those home care programs until the responsibility is assumed by the multiservice agency. In Toronto, for example, the public health units

aren't involved in the delivery of the home care program; an independent board does it. This obligation, while technically on the public health board in Metro, certainly doesn't interfere with the minister's ability to fund home care in Metro.

The Vice-Chair: Do you have any comments about that before concluding?

Ms Bowman: We were just raising it as a potential concern, that a health unit that may not want to continue with home care, may choose not to seek approval as an approved agency, may fall between the cracks. That was the reason we raised it.

Mr Quirt: If a public health unit or municipality chose now not to continue to deliver the home care program, no doubt other arrangements would be made.

Ms Bowman: Thank you.

1550

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Vice-Chair: Next is the Ontario Public Service Employees Union. Please come forward and introduce yourselves, and welcome to the committee.

Mr Bob Reid: Good afternoon. We appreciate the opportunity to make a presentation today on Bill 173. I am Bob Reid, executive board member of the Ontario Public Service Employees Union, and accompanying me this afternoon is Tracey Mussett, who is a member of Local 477 at the Renfrew County and District Health Unit.

We have submitted to you a written brief which outlines our concerns about Bill 173 and the direction long-term care reform is taking. I will, as time permits, emphasize several key issues here today, and then we will be pleased to answer questions from the committee on our presentation.

OPSEU represents 110,000 public sector workers across the province. Of those, close to 20,000 are engaged in the delivery of health care services.

OPSEU members are concerned about long-term care reform and about Bill 173 because they work in acute and chronic care hospitals, psychiatric hospitals and community mental health agencies, homes for the aged, nursing homes, home care agencies and ambulance services, government-run facilities and community agencies that care for physically and developmentally disabled people, community agencies that offer wellness and recreational programs for aged persons, and government-run monitoring, compliance and support operations.

OPSEU members are the educators who train the health care workers in community colleges.

OPSEU members are consumers of health care services. Many care for elderly and chronically ill family members. Our members are community activists and volunteers. OPSEU members are taxpayers.

The reform of the long-term care system is an important and emotional issue for all our members.

OPSEU has put considerable thought into what makes quality care.

Our health care goals demand: the promotion of wellness, autonomy, independence, dignity and choice; a

continuum of care; cultural sensitivity; quality, accessibility and enforceable standards; full funding; non-profit, regulated settings; and government accountability.

We believe that the reform of Ontario's system of long-term care services is overdue. The existing system is fragmented, unplanned, uncoordinated, poorly regulated and out of touch with real needs.

OPSEU has been working hard to help this government see the need for real change, change that is based on real needs of real people.

Our members support the objectives of Bill 173. We have serious concerns, however, about the gap between the rhetoric of those objectives and the reality of the process and the outcomes. We have serious concerns about the effects, the real effects, for all of us.

The rhetoric and the reality:

The government says we must build a new kind of health care system. The government says we must make the most efficient, effective use of our public resources. The government says the system must be accessible and consumer-focused. The government says it is shifting funds in the health budget so it can fund more community services to seniors. They talk about providing support to the community and families. They say Bill 173 recognizes the importance of a person's needs and preferences in all aspects of community services. They say they are decentralizing decision-making so there can be more local planning and participation by consumers. The government talks about the importance of direct involvement of front-line workers in the reform and restructuring taking place across the province. They say Bill 173 is designed to encourage and support early progress towards the establishment of multiservice agencies.

OPSEU says that is the rhetoric. We see the reality.

We see our members working in downsized facilities, afraid for the future, although they have been assured that there are new and improved community jobs coming. We see workers in the community now without the ability to bargain collectively for adequate compensation and good working conditions. We see women working in jobs with no guarantee of hours and no job security.

We see women trying to support a family single-handedly, working part-time jobs with no benefits, now also coping with service cuts and user fees. We see workers who are expected to increase their skill and training levels to keep pace with this reform, without the incentive of an increase in compensation.

We see women taking vacation leave or leaving the paid workforce to care for family members and neighbours. We see women becoming sick themselves from trying to deal with the working stress, the guilt and the added responsibilities in their homes and their communities. We see sick and elderly people having to rely on family members or community volunteers for care previously provided to them by trained professionals in safe environments.

We see consumers and working people who want to be informed and involved in what is happening in their workplace and their communities trying to attend exclus-

ive meetings and daytime forums with limited resources, only to be told their participation poses a conflict of interest.

We see a system that names labour as a partner and then marginalizes us. We see a reform system that fails to recognize the number of taxpayers organized labour represents. We see local planning bodies without equitable representation.

We see our members, who used to enjoy their work, who genuinely care for people, now frustrated, frightened and angered by the level of care they see given because of budget cuts.

We see women whose quality of life has drastically deteriorated and yet are still expected to offer loving and selfless care and nurturing to the entire world because it is assumed to be their nature.

We hear people talking about facilities as though they are bleak, uncaring, last-resort dumping grounds for people whose families don't want them.

We hear this government talking about "community" as though it is something warm and cosy that it just invented.

We see people living in complete isolation in cities and in rural areas.

We see a lot of people who have no idea what is happening to our health care system and what Bill 173 means because the information is not available to them.

We see a health care system that continues to discriminate against women and the elderly.

We see facility-based care being cut before fully funded community support is in place.

We see a system that fails to recognize the existing high-quality, available, well-accessed programs which are now offered by hospitals and other facilities. We see a system that expects each community to come up with its own strategies without sufficient funding, with workers and consumers left to suffer. We see communities being rushed into implementation without adequate information about transitional issues.

We see meaningful discussions about employment security being set aside, centrally and locally, as if it can be discussed later, while workers are being affected now.

We see this government offloading the responsibility for negotiating employment adjustment strategies on to the community.

We see a system that continues to try to reform itself ignoring the insights and the ideas of those who will bear the brunt of that reform.

We hear talk about better services, but we see that what is meant is cheaper service, a system driven by the corporate agenda and bottom line. We hear the panic created about the cost of the health care system. We have talked about waste that could be controlled without cutting services and without adding unemployment.

We hear the Ministry of Health say that it has determined that unemployment and stress have a negative impact on health, while it adds daily to the insecurity of workers in the health care system.

In both facilities and community-based workplaces, we

see our members continue to make the system work, for the sake of those they care for, at their own expense.

We see a system that fails to recognize that user fees put the burden of cost on those least able to pay: the sick, the disabled, the elderly and low-income families.

The reality is that Bill 173 will contribute to higher health and social costs for us all. The reality is that Bill 173 reduces our right to care.

Our brief addresses these concerns more fully. I would like as a conclusion to highlight some of our recommendations regarding Bill 173 and long-term care reform in general.

OPSEU and the other health care unions have proposed a province-wide employment security agreement. Instead of trying to negotiate from scratch in each community, we believe it makes sense for all the players—unions, government and employers—to advance a single province-wide approach to employment security. As the Ministry of Health says it wants to maintain a quality service, and that changes in sector should not lead to unemployment for front-line workers, an employment security agreement makes a lot of sense.

1600

Our proposal moves us beyond the social contract and provides for a neutral place to have discussions so that all unions can participate. It does not contradict any part of the health care sector agreement and builds on the positive aspects. With such an agreement, the ministry would save valuable time and money.

OPSEU supports the health sector training and adjustment program, which includes labour as a full partner. We recommend that the use of the jobs registry, matching available workers with available work, be mandatory in order for HSTAP to fulfil its mandate.

OPSEU supports the OFL-ONA proposal which calls for a nomination process, which would ensure that labour has legitimate and accountable representation on district health councils and their committees.

We believe we are the ones who should define what a labour perspective is. OPSEU members are concerned about the fragmentation of the consultation and planning process. There are many committees and advisory groups where labour has not been able to provide input. We recommend, therefore, that a labour liaison committee be established which would allow the unions to review the community services reform and implementation issues with the ministry in a more coordinated manner.

OPSEU members are very concerned about the shift of the family on to women. We have some concerns about the expectations that will be placed on communities and volunteers. We urge the government to revisit these issues with labour's input when it makes its revisions to this bill.

We thank you for your attention and we will be pleased to answer any questions.

Mrs O'Neill: I'm very pleased that you brought the case the way you did. I do think there's an awful lot of rhetoric around this bill. I think it has caused confusion and fear among people like yourselves as well as the people you work with and for.

I am very happy that you were able to put on the record that you represent 20,000 people and that your efforts to become meaningfully involved have not been met. I think that's important.

I'm glad you went into detail about the employment adjustment and compensation spinoffs because there's not much being said about that. Certainly, if the rest of the agenda of this government is to be meaningful at all, those things have to be on the table on this important issue.

The thing I think you have pointed out that no one else has is the effect this bill is going to have on women: women who are workers and women in their homes who are going to try to provide services that will no longer be there, so for that I thank you.

There's such limited time in these hearings that I have to also limit my remarks, and I'd like to go to two of the things you've said and ask you to expand a bit on them. I think you would likely have a perspective that maybe not everyone has.

"We see the sick and elderly having to rely on family members or community volunteers for care previously provided for them by trained professionals in safe environments." Could you be a little more specific about that particular statement?

Mr Reid: If you don't mind, if we have an opportunity, we both would like to respond on various issues.

The way I see that, being in the health care profession myself and being a professional who supplies health care in the community in London, I'm well aware of what's there for support services. When services are changed to go out from institutional care or from the acute care setting into expanding the community setting, the services aren't there. When elderly or people who need assistance with homemakers expect those services to be there to assist them in their daily life, there's a variance in the way services are provided. Those services may be employed by even the well-to-do, where they expect somebody to come in to supply those services and yet they come in to do the dishes or something else like this, which is not supplying home care.

Mrs O'Neill: Are you confident that Bill 173 will fix that all up?

Mr Reid: Yes.

Mrs O'Neill: You really do think it will.

Mr Reid: If we can look at and expand and ensure that the services are going to be there.

Mrs O'Neill: Without a financial commitment, it's going to be more difficult.

Mr Reid: Without the financial commitment.

Mrs O'Neill: And without the job security you're asking for.

Mr Reid: The way the system has been going so far is that there has been a downsizing of the systems in both the acute care and the community side of health care delivery, and that has happened basically on the backs of front-line workers.

Mrs O'Neill: Exactly.

Mr Reid: So it's been a downsizing of the system.

The money has not been there, so it's been a downsizing of the system. When you downsize the system, then also therefore you're not supplying the services that are expected. You're leaving holes and you're leaving gaps and you're expecting that the majority of that work is going to be picked up by those who are left in the system in order to provide that care. As a front-line worker, we see this happening over and over, and when I say that, the stress that the workers feel is because they're getting stressed out with the fact that they're not able to supply that care that they once used to be able to supply because the time frame isn't there. They have that much more work that they have to perform in a certain period of time and they can't provide that quality of care that's there.

Mrs O'Neill: That's why I'm concerned about the expectations around this bill.

I just have one other area that I have time to ask you about. We hear this government talking about the community as though it was something warm and cosy that it just invented. There's been a lot of discussion about the word "community" even this morning. Would you like to say a little bit about how you feel that could be better placed in the bill or how communities could be involved as a result of Bill 173?

Ms Tracey Mussett: I think the first thing we want to say, and we said this last year when we came to speak about Bill 101, is that what's needed in terms of a community to support this bill is not necessarily what is really out there. I think that the funding mechanism that this system is going to use, based on a fixed number of dollars and not based on need, defeats the whole idea of a community planning for providing the service and then supporting the service, because if the funding is not based on need but the community is obligated to provide for the needs it's identified, you're not going to have a fit. You're going to have a community with huge gaps in service and I think that's where we end up with family and volunteers trying to provide service that there are not the dollars for. I think that if this bill is going to ensure an array of services, we need to see some assurance that that array of service is going to be funded to the level that the needs need. It needs to be funded to deliver a level and a quality of service that matches the needs that the communities have identified and planned for, and we don't see that.

Mrs O'Neill: Thank you for bringing reality to the discussion.

Mr Reid: If I may be permitted to give an example, when the government started looking at deinstitutionalizing the institutions where the adult mentally retarded were in, we started putting them out into the community, into the association of mentally retarded or group homes. The moneys weren't there. The government support and the assistance from the community was not there for those people. We ended up that a number of those people who were expecting and should have gotten that support from the community are now, a good portion of them, homeless and a good percentage of them are in correctional facilities because the community support was not there. We have concerns.

Mrs O'Neill: So do I.

Mr Reid: If we're setting up this type of thing in health care, are those services going to be there for those people when they need it? We don't want to see the same thing happen with this bill and this move to multi-service agencies and to a broader community health care or delivery system meeting the same kind of fate as what those people did that we gave them.

Mr Jim Wilson: Thank you for your presentation. A number of the points you raised have been raised by other presenters. In particular with the reform that's gone on over the past couple of years, things were supposed to get better, and you certainly get a feeling in my area of the province things didn't get better. We've had a reduction of real front-line workers also, providers. You're from London, Ontario. The government began this set of hearings again with telling us about all the money it's transferred from the institutional side, hospitals primarily, to community-based services. Can you give us a feel for how things are in your—have things gotten better over the last couple of years?

Mr Reid: I would say that things are just starting to boil there. Being part of a committee that also sits on a district health council and with the restructuring aspect of health care delivery in the London area, we're just at the beginning process, but it will have, in a window time frame of some 18 months, probably a dramatic impact on the London area and the health care service delivery that goes on there. So it's very difficult to say at this time.

1610

I know that there has been significant reduction in health care workers in that area. I know the attitudes and the feelings of people working in all the hospitals around that area and they're terrified. They're terrified for their jobs, they're terrified of what the health care system is going to be. There's no portability as far as their jobs go any more because the work market has shrunk so much, the dollars aren't there, and with the added increase in the workload, there are a lot more people who are being stressed and there's more sick time. It's a domino effect and when this happens, the quality of health care delivery definitely I think is deteriorating because I think we're putting too much on too few people.

Mr Jim Wilson: I just ask the question, I think it's a fair question, because the minister keeps telling us about upwards to 60% increase in some of the community-based budgets. If you look at the government's estimates, for example, there are several hundred millions of dollars taken off the institutional side that are supposedly being spent on the community-based side. Yet since I've travelled the province, I haven't been to any communities where things are actually improving.

I suspect a lot of the money, when you look at the fine print on the estimates, is just going into administration and new bureaucracies, and my worry is and what we've contended is—and I'm wondering if you have the same worry—that MSAs are just going to become another layer. I want to ask you particularly, because you're on the DHC in London and you guys are going through the regional stuff in London right now where there's always worry about, "Are we setting up another layer?" Specifically with MSAs, though, do you share the concern that

a lot of people have told us, that it's just going to be another layer of bureaucracy?

Mr Reid: I think that's one of our fears, that it probably would be, that it has the potential of being so. Actually, what it should be and what it should represent is that it should break down the layers of bureaucracy, it should eliminate the number of boards that there are across the community for all the agencies. It should consolidate the administrative aspects of all community health delivery and be more focused on providing health care rather than the administration and the bureaucratic aspect of it.

Mr Jim Wilson: I appreciate your honest answer on this. At first glance, when you think you're going to be—we're the party that did regional government originally in this province and we still can't get elected in those areas. Originally you were going to tear down some of these small administrations, and they do turn out to be fairly small administrations, and replace them with, in this case, the MSAs, the new regional government for health care, at least on the community-based side. History has shown that things don't get any cheaper or more efficient, that the "bigger is better" attitude doesn't hold out and that the bureaucracy actually gets bigger.

For instance, in Simcoe county we have seven groups and it's 97% non-profit, so it isn't one of these arguments about the private sector versus the non-profit sector. They have a lot of voluntary—I mean "voluntary" in terms of the talk that goes back and forth, the communication between their groups, the referrals between groups that's going on now, and they can make a case that the seven of them, the VON and the Red Cross and that, are fairly efficient now. If I look at their administrative structures, they're not that large.

I have a feeling the MSA for Simcoe county—because there may be more than one MSA in Simcoe county—will end up having more bureaucracy than the seven little groups I have now. Is that good? It didn't turn out to be good for school boards, it didn't turn out to be good for regional government, and now we're doing it in health care. Have we not learned anything in 20 years in this province with these experiments? That's my question to you.

Mr Reid: It's a difficult question to answer because—

Mr Jim Wilson: Because some of these non-profit groups, agencies—now I know that OPSEU might have a little concern about a lot of the work volunteers are doing and, in fact, are going to be encouraged to do more, I guess, under this bill, if they can get volunteers for an MSA—they're really not that large. Some of my local VONs have an executive director, a couple of people who work in the office and a lot of front-line workers. The administration isn't that large. They could make an argument that the administration is just going to get bigger under an MSA.

Mr Reid: Yes.

Mr Jim Wilson: And then we won't save any money.

Ms Mussett: I think the idea of one agency in terms of improving accessibility and a coordinated approach is not something we have a difficulty with.

Mr Jim Wilson: No, neither do I. The original idea, though, it was going to be one-phone-number type of thing, one intake office.

Ms Mussett: That may still be the case in some communities, and I think a community is the best place to decide what, in fact, works for their community. There's such a diversity within urban communities, let alone the difference between urban and rural, and I think a community will decide that, yes, the buildings will stay the same but there'll be one phone number, if that's what suits them.

Regardless of whether it's an MSA design or a whatever design, the way they have been working through the process and what they call consultation and what they are saying is consumer need and what we're saying is dollar-driven is what the problem is. In the meantime, they're shifting a lot of the responsibility on to families.

In the brief we refer to the consumers asking to be allowed to stay at home, and to me "allow" means the choice to stay at home, not that that's the only place they can now receive service. Families will be allowed to care for their families, but I don't think there are families who would like the government to demand that they provide service that we say is a vital human health service.

The reality is that we're talking about women as family care givers, and I was one, and the reality is that a lot of women are now in the paid workforce and I don't know where the hours in the day are going to come from to provide that quality of service.

Again, we're not disputing that an MSA may be a good idea. What we're saying is that the process and some of the outcomes that we see, because of things that are missing in the bill and may well be covered off in the regulations, are things that have a direct impact on quality of care and quality of work.

Mr O'Connor: I appreciate you coming forward today. On looking through this brief, "The Rhetoric and the Reality," it certainly is a good name for it. I find it somewhat disappointing because quite often I have respected the union movement for approaching things in a more open fashion.

The reality is that if we take a look at the money put into the community by the present government—in 1990-91, the community side, there was \$550 million. This fiscal year, \$850 million will be put in there. That's a 54% increase. That is a reality that I would hope maybe you'd recognize.

I don't know whether you're aware of the MSAs being given the responsibility to develop a human resources plan, a plan to take a look at the effects that they would have within their local communities. If you've got some suggestions how that might be accomplished, I'd appreciate that.

This morning we had some very interesting presentations, one by the Ontario Coalition of Senior Citizens' Organizations. They represented the consumer side and quite often when we've seen involvement at district health councils, for example, by local labour reps, they've been able to bring forward a different perspective as consumers of many services. I know this may be an area

where you might have difficulty in representing some of the consumers' concerns.

1620

I think the importance that they presented was that the see the benefit of a single access point. There's definitely a benefit. I know that as MPPs, when we go out and knock on a few doors to talk to some people, one woman I met last Thursday afternoon, who's slowly going blind, can take care of herself quite well but is going to have problems going to get groceries. Where does she fit into that system? She doesn't know, but if there's one access point—the first part of the services she's going to need is going to be light, and they will become more demanding as she ages, no doubt, but that one access point for her is going to make a big difference.

I think that was the focus we heard this morning, and I hope that as we continue the hearings we're going to hear some of the focus towards the consumers, because the money is being put into the community. There's a real commitment by the government to put the dollars forward that are necessary. The focus here needs to be on the community, and I think there are very important roles that labour can play in approaching the needs of the community: direct involvement with the district health councils, membership on MSAs. But at the same time, let's try to keep a focus that the intention here is to bring forward some service that is important to the seniors, to the consumers, to somebody who is disabled, who needs to have that single access point.

Mr Reid: To answer some of your questions, first of all, we've always advocated the fact that as health care providers, we are the advocacy for the community, for consumers and for the communities that we live in, because we know. We deal with the people face to face.

You talk about, how would labour fit in with the human resources planning? To me, it seems rather ludicrous to in some degree start doing human resources planning on such a broad scale without involving labour's input, whether it be organized or whether it be unorganized. The people who are working in the field supplying the services definitely have a lot of input into how human resources planning should go, and they should be included in that process.

Probably one of the better ways of being able to do that is their involvement within district health councils, because the district health councils are the ones that are being charged with the responsibility, through the ministry, of developing the MSAs and also with all the other aspects of health care restructuring, and it's important that there is that labour perspective, that health care provider perspective, and also, by being that, as I said, they're also giving a community perspective, because we're not only providers, we're also consumers.

It balances out and gives a good balance as far as representation goes, because sitting on a number of different committees on district health councils, I can give you a fairly good insight as to who sits on district health councils, and it is probably, in the majority of the cases, the more well-to-do, well-established administrative people, company CEOs, the upper 4% or 5% of the community.

Now, sitting as a provider not up in that 5% of that community, I wouldn't say that is totally representative of the community as a whole. So to get that perspective from those people who are actually doing the work and who actually know what's going on and what is needed and talk to the people and talk to the community, then you're going to get a much more productive way of being able to go through this transition in the way we provide services.

Mr Malkowski: Thank you for your presentation. It's interesting to hear some of your feedback on the labour perspective. It's important to us and your words are important to us.

You mentioned employment security. I know that's an important perspective that we, as a government, do care about, so I'd like to direct my question to the parliamentary assistant to the minister and ask, the \$850 million, the infusion of new funds that we've increased, what percentage of that will go in employment security and where is it balanced for some people as long-term care becomes a reality? I'd like your comments on how employment security will be achieved.

Mr Wessinger: With respect to the question of employment security, I understand the minister has indicated on several occasions that unless there's a human services plan in effect with respect to an MSA that provides for the fair dealing with the employee situation, the MSA will not be approved. That's, as I understand it, the mechanism of ensuring that there is a protection, a security provided to employees.

I must say, one of the aspects of the MSA is to try to divert more resources to front-line employees rather than to have as much spent on administration, so certainly one of the purposes of the MSA is to create more front-service positions. Also, if we look at the history, as I understand it, approximately 5,000 jobs have been created in the past in the long-term care area.

I don't know whether the policy adviser can add anything to what I've said.

Mr Quirt: Just specific to the member's question about the distribution of funding, there was \$647 million committed to investment in the long-term care system; \$206 million was invested in the budgets of the existing long-term care facilities; the remaining \$157 million went into those budgets on July 1, 1993. On the community side, we've invested roughly \$250 million of \$441 million over the past three years, and we expect \$200 million more to be invested in 1995-96 and 1996-97, the balance of the \$647 million.

Mr Malkowski: A supplementary, if I might, to follow up on that point: Given that, what kind of guarantees would you look for and what guarantees should labour look for, in an MSA, on employment security? Could you talk a little bit about that, and from your own experience, as a union and a labour movement, what kinds of securities would you like to see built in, or how could we improve the legislation to satisfy you a bit more? What would you like to say to that?

Ms Mussett: I think the proposal that OPSEU, as an affiliate of the OFL with ONA and AAHPPO, has been

working on, an agreement that would be a more efficient and a more equitable way to approach labour adjustment province-wide.

I have a real problem with the MSAs being responsible for creating a human resources plan when we are saying to you today that labour does not have equitable representation on those committees that are doing the plan. I'm not sure if we are going to be partners with the ministry in reviewing those human resources plans as agencies apply to be MSAs, to help you decide that yes, that's a good human resources plan.

1630

I think that the agreement we have been trying to work with the ministry on and, as I mentioned, we're including the employers in negotiating, that sort of thing helps set a framework for more mobility for workers. If a human resources plan limits workers to make employment adjustment within just the region of the MSA, I'm not sure that's enough employment security for people.

The ministry has said that the adjustments in the health sector, including the downsizing, should not lead to more unemployment, and we have been told that there will be more community jobs. But regardless of what the numbers say on paper, and I appreciate it when you say to me so many millions of dollars are going to the community, what we're saying to you today is that we are in the community, at the front lines, and those dollars are not making it through. I am still providing care to my family over and above what I personally am able to do and still maintain a quality of life that I think we assume is an entitlement for everybody in the province.

The rhetoric, if you're spending \$500 million, \$500 billion, what we're saying to you is, the system as it exists today has problems, and we're not trying to imply that that's been created recently, what we're saying is that a reality check has to be done, and let's look at what really is the picture out there. Then, if the MSA design is one that proves to be reasonable—and again I would like to stress that we're not talking about a cheaper system; we're talking about a better system—if the MSA design is one that seems feasible, then let's look at how it can be made accessible and how it can be made equitable and let's make sure that it provides the services to the needs of the people who have said they want access. Providing access and having no service is not going to do anybody any good.

We have a large retirees' division who are members of OCSCO, the group you referred to this morning, and we have determined that over most of the issues surrounding Bill 173 we are allies in our position. So we certainly have been listening to consumers ourselves, and that's how we've developed our opinions about a lot of this bill.

Mr Malkowski: Thank you very much for the feedback.

SAINT ELIZABETH VISITING NURSES
STAFF ASSOCIATION

The Vice-Chair: The next presentation will be made by representatives of the Saint Elizabeth Visiting Nurses Staff Association. Welcome to the committee. Please

introduce yourselves and proceed with your presentation.

Ms Laurie Clapperton: I am Laurie Clapperton from Saint Elizabeth's, and on my left is Heather Findlay, one of the nurses I work with, and Judy Franks.

I am pleased to appear before you today representing the Saint Elizabeth Visiting Nurses Staff Association. We have three nursing staff associations, one in each of Metro Toronto, Peel and Durham. The staff association at Saint Elizabeth's is made up of representatives who are employees who do not exercise any managerial or supervisory authority over other employees. These representatives are elected by their peers to promote and facilitate communication between staff and management and to promote a better understanding of the responsibility and concerns of staff and management. I am chairperson of the Metro staff association, but I am speaking on behalf of all three divisions.

I have been a nurse for eight years. For the first four years of my career I worked in a hospital, most of that time spent in the emergency department, but the last four I have worked with Saint Elizabeth's. The main reason I made this change was because hospital work was becoming increasingly removed from the real reason I had become a nurse in the first place. Hospital care is medically driven, and by its very nature and the hospital setting, it is difficult to address the psychological and social needs of clients. I wanted to work directly with clients in their homes, where this setting is more conducive to dealing with their overall needs. This type of approach is part of the philosophy of Saint Elizabeth's.

We work in people's homes, providing holistic care that includes giving treatments, teaching clients or their family members to administer some procedures, providing counselling and support and generally promoting good health. Our care helps to increase the independence of our clients and their families. These things are, for my colleagues and me, important elements of being a nurse and are vital components of the job we do.

Our biggest concern on an ongoing basis is the quality of care we are able to give our clients. Providing high-quality care which enables them to live more comfortable and independent lives, remain with their families and offers them choices is the driving force behind Saint Elizabeth's. This is the main reason we are concerned about Bill 173. We do not see how, under the new proposed structure, clients will be able to receive the same type of high-quality home care that we currently give them.

I would like to relate to you two examples of the type of care that we currently provide that is reflective of Saint Elizabeth's. I believe they show why the current system of having independent organizations such as Saint Elizabeth's should be maintained to ensure the continuance of high-quality care in Ontario.

The essence of community-based care is to be able to have the necessary health care services provided safely in the home so that the client is more comfortable, in familiar surroundings and given the necessary attention, not just by health care personnel but also by friends and family.

Recently, a client of mine died. She was faced with a terminal illness and was not being offered any treatment and she chose to stay at home, as many people wish to. My colleagues and I provided the nursing assistance that was necessary, helping to control her pain and teaching her family how to meet her personal needs. But more important was the fact that her friends and family, the people who loved her most in this life, were able to provide the care for her, making her feel loved and comfortable until the end.

This would not have been possible in a hospital, and in this case was only made possible because of the services provided by Saint Elizabeth's nurses. She was in her own bed, surrounded by all of her family, including her elderly husband, who would have found it difficult travelling to the hospital to visit her. This is the essence of dying with dignity, and I am not sure this type of care will be able to continue under the proposed system.

A second case is an ongoing one of a little boy trying to live a normal life. He requires a very expensive drug in order to live. Originally, he was going to a community clinic once every two weeks for treatment. Then new research showed that this drug could be as effective if it was administered more frequently but with a much lower dose. This would help ensure more balanced usage and decrease the total cost, as this is one of the most expensive drugs in the world. The problem was that for him to visit the clinic for this treatment would mean missing part of a school day twice a week.

This problem was solved when he was referred to us. I now go to his home after school and give him his treatments, by which time his mother has arrived home from work. The result is that he is able to have a normal school life, be more comfortable when receiving his treatments and is now learning to give them himself. Eventually my services will not be required. Had he been forced to attend the clinic, his life would have been disrupted and he would not be making the type of progress he currently is. This is the type of care that we should be trying to achieve and expand.

These two examples are common of the types of services Saint Elizabeth's nurses develop and provide on an ongoing basis. We are always striving to offer better, innovative and more flexible care based on the needs and choices of our clients. Under the proposed MSA structure, we see no guarantee that we will be able to continue to provide these types of services, nor that clients would even be able to choose us to provide any services. This does not signal improvements in the quality of long-term care to Ontarians.

The people who are the care givers are a key component to providing quality care. With the provisions contained in Bill 173, we do not believe that nurses will be either encouraged or motivated the way we are at Saint Elizabeth's.

All nurses are different. Not all want to provide specialized services, nor are all suited to working independently, which is a key requirement of my job.

It appears to us, particularly given the fact that MSAs will be self-contained within defined geographic boundaries, that the emphasis will be on all nurses providing all

services. This is neither practical nor feasible. Many treatments require specialized training and constant usage in order to maintain a high level of skill which will ensure the most comfortable and safe treatment for the client. This is unlikely to happen if nurses are assigned to a relatively small geographic region and are expected to provide a multitude of services. The needs of the clients and the individuality of their situations must be taken into consideration and matched with the appropriate nurses to ensure the highest standard of care possible. How will MSAs be able to ensure this type of individual care exists?

As well, Saint Elizabeth's nurses are concerned that passage of this legislation will make all the members of my staff association employees of the MSA government structure. This is not a change which, with all due respect, we would support. Saint Elizabeth's sets very high standards for its nurses and the services we provide. The working environment energizes nurses and creates a significant degree of loyalty to the organization. The organization is very supportive of its nurses and has a very strong commitment to promoting and training nurses, if they desire.

For a nurse who wants to obtain education in a number of specialized areas, the opportunity is provided by way of paid education days and exchange programs with other providers. For a nurse who wants to provide basic nursing services, that desire is also supported. The opportunity for advancement exists and is based on qualifications and desire, not just seniority.

This is something we fear would be dramatically changed if we were forced to become MSA employees. If this change was to occur, we believe much of the motivation for being a nurse with Saint Elizabeth's would disappear and the quality of staff and their commitment would decline.

1640

As well, as the needs of the community change, Saint Elizabeth's looks for new opportunities and new ways of providing services. In a general way, this can be seen by the changes that have taken place during our 86-year history. We have moved from providing home care for mothers and babies to giving a wide range of complex treatments. We seek out the needs of the communities we serve and try to develop new services which will address these needs.

A prime example is the home chemotherapy program we developed over three years ago, which is particularly helpful to people who have difficulty travelling. Clients are referred from hospitals or cancer clinics to home care, who then refer them to us. As specialized training was required to provide these treatments, two of us who are interested in this area were given intensive training. After the first year of providing the service on a test basis, the project was deemed successful and the decision made to continue it.

The service has grown to involve four specially trained nurses who are able to provide this therapy to the people who need it. The result is that individuals are no longer required to leave their homes and wait around in hospitals or clinics for their treatment. This service is not provided

in the same comprehensive manner anywhere else in Ontario.

A second example is the Saint Elizabeth's mental health program. This program helps treat the psychiatric as well as the physical needs of clients. A team of mental health nurses provides the necessary care in the homes, with the result being that patients, clients, can remain in their homes longer and avoid hospitalization.

Services like this provide breakthroughs in terms of treating people, but in part are developed only because of the healthy competition which exists between health agencies. As in any type of service operation or business, the competition between agencies helps to generate new ideas, new treatments and, in the end, more choices and types of care for clients. This is a strength of our current system that must be maintained. We fear this environment will not exist with the introduction of MSAs.

While I have primarily raised the areas of Bill 173 with which we don't agree, there are sections of the bill which we support. These include the proposed patients' bill of rights and improved access to information on services. We commend the government for trying to make these changes.

However, the way to achieve these goals is not to create large organizations such as MSAs which are responsible for providing services as well as providing information. Health care services are just not that easy to dispense. Rather than continue down this road, we urge the government to consider changes to this policy that will allow easier access to the services without having to actually provide the services themselves.

Ms Carter: I feel as though what you're saying is kind of going parallel to what we're trying to do in this bill, but that because you're afraid somehow of the changes and how they may go, you're not seeing that.

I think most people in the province now don't have the opportunity to choose a Saint Elizabeth's nurse. The people who do are obviously lucky; you obviously have a very flexible and devoted service. But one of the government's concerns is that this kind of care is not available all over the province, and what we're trying to do in this bill is to make sure that the best of the services we have now are going to be available on a province-wide basis, so that somebody living in some rural area that's maybe not very well provided for will have the same essential services that somebody in Toronto might have.

Also, of course, we are emphasizing community care. You seem to be saying that perhaps people are going to be forced to stay in hospitals instead of being looked after in this more flexible way in the community. I don't feel that is the case.

Also, I don't think the disruption is going to be quite so drastic. There will be a coming together of organizations, but I don't think they're going to just be totally overturned, and of course there is a four-year time for the transition to take place.

Now, a question I have for you is, the basic change to the multiservice agency is happening at the local level, so the process won't be the same in each area because it is

locally driven and concerned people in the area are working on these committees and forming the way that it's going to happen in their area. Are you people involved in that work in your areas? Are you taking part in the process so it will happen in the way that you feel is most beneficial?

Ms Clapperton: I'll do my best to answer your question. Certainly people within my organization have been very involved on different levels in the last two and a half years, and I guess the concern of ours here today is, again, the quality of care. What it comes down to is that we have been offering these services, and certainly Saint Elizabeth's has made every effort to expand the type of care into other areas. As a non-profit agency, it would certainly benefit the government to have contracts with Saint Elizabeth in other areas of Ontario. Those contracts have not come up to date in areas other than the Peel and Durham area as well as Metropolitan.

Again, coming back to the quality of care to the clients, certainly we'd love to be able to offer our services in other areas and have expanded up to York and into Kingston so that those services will be available to the clients and to the communities there. I'm not sure that I clearly answered your question.

Ms Carter: Of course, you did mention the bill of rights, and of course there'll also be plans of care for each individual consumer, so hopefully there will be that flexibility to make sure they will get the care that they need. Also, of course, and I think it has only been mentioned once in these discussions so far, the Advocacy Act is coming into force. That will give consumers, however frail or whatever they may be, the chance to make their opinions known, and if they aren't being treated in the way that they feel is ideal, they will have that channel of communication. So I think the consumer is going to be looked after. That's certainly what the intention is.

Of course, another point at issue is that you feel that it would be better if we had the one-stop access but then that the organizations delivering the care should be separate. The feeling I think in drafting this act was that by having both the assessment and the delivery within the same organization, you do get an increase in efficiency, you reduce costs, you have easier communications. Do you have any comment on that? Do you not see those as some plus factors?

Ms Clapperton: I would have a comment in regard to that, because, number one, with the MSA structure it is my understanding that the different services are going to be lumped together and, as such, the health care that's provided by the nurses in the community is a very unique type of service requiring a lot of education and, again, maintaining the skills of the nurses, because we work alone in the patients' homes and a lot of the things that we do would have a very detrimental effect on our clients if they were not done, carried out, in the appropriate manner by knowledgeable and skilled nurses.

Because our organization is a structure built on offering these health care services to our clients, as well as the organization, right up to our CEO, our RNs, who fully understand the needs of our clients as well as the

educational needs of our nurses, by lumping all of the services together, what you're doing is combining them, where some people perhaps are not going to get the full services that are being offered now.

Yesterday I believe it was mentioned for the government to still be able to contract out to the different agencies for the work, if people are still getting the high-quality care in the home, and the services, and it's still being done by being able to contract out to the individual agencies that are already in the community and have been providing that care and providing it very well for over 85 years.

1650

Mr McGuinty: Thank you for your presentation. I believe that the question we should be holding before ourselves here as members who sit on this committee is what is in the interests of the consumer at the end of the day, not what is in the interests of the various providers, with all due respect.

Of course, that's an important consideration, but at the end of the day, paramountcy has to be given to the interests of the consumers. You know, we've been talking about a bill of rights, and one has been drafted and inserted in the bill. It seems to me one of the rights I should have is the right to choose, and particularly, as an extension to that, the right to fire somebody. If I don't think they're doing the job for me, I would like to have the right to fire them and bring somebody else in, and my concern is that our consumers won't have that right.

I have every reason to believe that your organization, like many others, brings a high level of skill, degree, care and compassion to the work that you do. I have my own reasons for believing that there would be problems, but you tell me: Why could we not, as the government is proposing, transpose that work ethic to the MSA? Let's assume now you're all working for the MSA. Why could we not bring all of that work ethic to that new workplace?

Ms Clapperton: I think number one is, you can't transport the heart and soul of the organization into a government structure. That comes down to our values and our missions: caring, providing care and compassionate services to our clients and providing that in a flexible way; not only meeting the needs of the clients as far as their services, but also the times in which—we do provide also 24-hour service to our clients. That is probably one of the main reasons why we can't transport it into a different, perhaps more government-structured, agency such as the MSA.

Second, we work as a team at Saint Elizabeth's. We are an agency where, as nurses, we've had a lot of input into how things are done at Saint Elizabeth's. We are the people who give the care. We are the ones who are in the homes seeing the patients. Patients talk to us and tell us what they need and how things will help them better. We are able to sit down with different managers in our agency and we're able to discuss those problems that we're having and give forth our ideas and our input in how to better service our clients.

The nurses at Saint Elizabeth's have a great deal of

input. We're listened to, and a lot of the policies and procedures and the different ways that we work reflect that. I don't believe that does happen in government structures.

Mr Jim Wilson: Thank you for your presentation. As I'm listening to the questions here, I think they're a bit skewed. Perhaps the wrong angle's being taken here, because I don't think it's incumbent upon you to justify why the government should be having MSAs. You're already doing a good job providing services.

I think it's incumbent upon the government, which wants to not only have one-stop shopping in the terms of one point of access, which I think most people agree with. There would be a little bit more ease in local communities for consumers or clients or people, as we really should be calling them, to get access to these services. But the government tells us that during their consultations they heard that the public also wanted the MSAs to deliver these services, and that's where we differ with the government because we certainly didn't hear that. That seems to be a last-minute twist that the government brought in, and hence we have this legislation as it's written.

I'm going to ask the government, because Mrs Carter claimed it's going to be cheaper and more efficient to have a bunch of school boards or a bunch of regional governments out there delivering these services, because that's the way I picture MSAs—I always compare it to the restructuring that's gone on under various governments on the municipal side, where somehow bigger is going to be better, and it turns out not to be that way—I'm going to ask the parliamentary assistant, do you have any studies or any paperwork on this at all to present to this committee how and why MSAs are going to be cheaper and better value for the taxpayers and the consumers of this province?

Mr Wessenger: Well, I certainly could respond to the question, but since it's specific on the question of studies, I will ask the policy person here.

Mr Quirt: No, there had been no study done that costed the multiservice agency model in comparison to the brokerage model that was the original preferred direction of the government as reflected in its consultation document, that is, the service coordination agency.

The government, through the consultation, received specific advice from two notable groups, the Senior Citizens' Consumer Alliance for Long-Term Care Reform, representing a large percentage of seniors in Ontario, and the Ontario Community Support Association, representing over 500 home support agencies and a variety of other service providers. Both recommended that the shift away from the brokerage model and the giving of the responsibility to the agencies that deliver service to also decide who is eligible for how much was a more streamlined system and would result in administrative efficiencies, moving from over 1,000 agencies with administrative costs to many fewer multiservice agencies.

I think it's a stretch to compare the multiservice agencies to a regional government structure, given that there will be 15 or 20 in Metro Toronto. I think it's fairer

to compare the multiservice agency to a variety of other charitable, not-for-profit corporations which are representative of their community and deliver a comprehensive range of services. Multiservice agencies' budgets will clearly be smaller than most hospitals and most children's aid societies and so on. So I think the notion of a large bureaucracy rivaling a regional government is perhaps not the best analogy to use for purposes of discussion here.

Mr Jim Wilson: Well, it is, because we went through committee hearings when they restructured Simcoe county recently, and they were taking 32 municipalities and making 16. You sell that to the public, and everyone thinks that's less bureaucracy, that's more efficient. Last year Simcoe county hit the first deficit in its 150-year history, \$1.9 million. They're back at the government's door.

I voted against it, my party did, but they're back at the government's door now saying: "Jeez, that restructuring is awfully difficult. We now have oodles of road superintendents and oodles of all kinds of people around. We've got to remap the place and we've got to do all kinds of things that they didn't think of." So don't tell me bigger is better, because it hasn't worked. In fact, I thought the style of government in the 1990s and beyond was going to be smaller autonomous groups that would think for themselves and make decisions for their local communities, and that's not what these MSAs are turning out.

I guess what I say to our presenters is, do your consumers think there's something wrong with the services you're delivering and they're begging that you get out of the business and set up an MSA? You deal with real people, right, not just two groups, Dan Stapleton and Jane Leitch, who I think should be subpoenaed to come back here and tell us on what basis they made that recommendation.

I think Mr Stapleton is coming tomorrow, and remind me, please, committee, to ask him that question: On what basis did he convince the government that we should move to an MSA, not just one-point access but have the government now delivering the services?

Mr Wessenger: You can ask him that question.

1700

Mr Jim Wilson: What's broken? Why are we going through this?

Ms Clapperton: Actually, I would be pleased to answer that. I think the biggest part of what I hear from patients and from what most of the nurses hear is that, number one, they actually are very pleased with the service and can't believe the things that are now being done in the home. But a lot of times people didn't know about it perhaps when they should have. They didn't know it was available. They didn't know until finally they were hospitalized and finally someone at the hospital realized that they might have a problem at home. They didn't know they could get this service or that it was available to them. I think that's a very big complaint that we've heard time and again.

Mr Jim Wilson: But that always occurs whether the government's running it or not. There could be a counter-

argument made that because there are a lot of agencies out there there's a lot of different contact, a lot of different fund-raising activities going on, so people know about the Red Cross and they know about the sisters and they know about—the surface area of exposure now is quite large because there are a lot of groups out there doing their thing and coming into contact.

Having one MSA you might actually reduce the contact with the public. I can't picture MSAs being any more proactive than the myriad of groups that are out there now. There will always be people who go without services because they don't know about them. We know that through—government has been in the past through multimillion-dollar ad campaigns and we find out our awareness is raised less than 1% or 0.5%. We see that in smoking campaigns all the time, TV ads and everything.

Maybe you'd agree. I can't see how the MSA is going to give them any more exposure; in fact, I think we get lots of exposure now with people coming into contact with them, mainly because of the fund-raising and volunteer activities. Think of the thousands and thousands of volunteers out there who are spreading the word about the organization or agency they volunteer for. MSA—I don't think you're going to have that.

Ms Clapperton: Also the different programs that we do offer now, we've linked up with a lot of the different community hospitals to be able to offer a lot of the different programs such as the home chemo program or the mental health program. Certainly people have become more and more aware of it, even particularly in the last five years because of those programs.

The Vice-Chair: Mr Jackson, did you have one short, urgent question?

Mr Jackson: Very briefly, in the last six or seven years there have been some substantive campaigns put on by your broad sector of health and support workers for the elderly because of funding cutbacks and because of cuts to anticipated revenue and for expansion of services. During those campaigns you took some risks politicking, but it was fairly easy because you were advocating for your client and you weren't sort of in direct conflict with the government.

Could you tell me how you envisage your new world under Bill 173 where you're essentially an employee of the government, and now how do you go and advocate? Who will be the advocates for these people, the clients, if in fact the front-line workers have been fulfilling that important role? And I mean publicly criticizing any government that its funding levels are down.

Mr Wessenger: Mr Chairman, I think Mr Jackson is not being accurate when he states that the people are going to—it's been clear that these are non-profit organizations, MSAs. They're not government-appointed directors, they're locally chosen. They're non-profit corporations, so I think it should be clear on the record that these are not government agencies. They are non-profit—

Mr Jackson: All government agencies are non-profit. I hate to break that big news to you.

Mr Wessenger: Well, no more than the—

Mr Jackson: It's in their nature not to make a profit, so if you think this is arm's length from government you're dreaming in Technicolor.

Mr Wessenger: It's the same—the MSAs are—

Mr Jackson: The parliamentary assistant has a—

The Vice-Chair: One speaker at a time, please.

Mr Wessenger: Mr Jackson, the MSAs are no different than—

Mr Jackson: Mr Chair, was that a point of order that interrupted me? Was that a point of order?

The Vice-Chair: Yes.

Mr Wessenger: It was a point of order. Yes, it was a point of order.

Mr Jackson: A retroactive point of order.

The Vice-Chair: Thank you for your comment. Had you finished your question? We'll ask the witness to respond.

Mr Jackson: I had completed my question. It was the deputants who were interrupted, not me.

The Vice-Chair: Thank you. Yes, did you wish to respond to the point made by Mr Jackson?

Ms Clapperton: I will try to. A big part of what we do now is we deal with the home care program and we do advocate very strongly on behalf of our clients because they are, in essence, the managers of the purse-strings and each visit is paid for by the home care program as are the supplies and any accessory assistance in the home such as homemaking.

So many times, when we're speaking on the phone to the person in the office, we are having to explain why the client needs these things and explain ourselves and what our role is in there, and that in fact gets the clients the services they need. In that way, we very strongly advocate for them and if within the MSA structure I am an employee of that MSA structure who is providing all services, I believe we will lose some of that ability to advocate for our clients and for their individual rights.

Mr Jackson: You are now the person on the other end of the phone.

Ms Clapperton: Yes, saying, "I'm sorry, no."

Mr Jackson: Yes.

The Vice-Chair: Thank you for your response. Ms Sullivan, you had an even shorter question.

Mrs Sullivan: Yes. It's a comment with respect to what I think was a real attempt by the government to, I suppose, underestimate the magnitude or size and scale of the multi-service agencies. I think that when we are looking at community-based services which the minister herself has predicted that in less than a year and a half will cost the taxpayer of the province well over \$1 billion, when we see neighbourhood agencies, such as Senior Link, which came in to appear before us today, discussing its local budget of \$7 million, and when we see population bases that these MSAs will cover of about a quarter of a million people in most communities, this isn't small potatoes stuff. This is not the neighbourhood agency, this is not the community agency that many people have been mistakenly convinced is going to

protect them and be their advocate and provide their services. This is big, broad stuff.

And while Mr Wilson has picked regional government as a comparative level, and it may not approximate regional government, it is certainly a similar style and the range of the process is comparable, even if perhaps the total value of services provided isn't quite the same. I think that nobody should kid anybody out there. This is big structure and that's not what I think those community consultations that you're so proud of ever contemplated.

The Vice-Chair: Thank you. Did you wish to comment briefly on that? Thank you for not commenting. Thank you for your presentation at this time.

ONTARIO PALLIATIVE CARE ASSOCIATION

The Vice-Chair: The next presentation will be made by the Ontario Palliative Care Association. We will limit our questions in future very, very much. Please take your seat, introduce yourselves and proceed with your presentation when you're ready. Welcome to the committee.

Mrs Shari Douglas: Thank you very much. I'm Shari Douglas and I'm president of the Ontario Palliative Care Association and a director of the national palliative care association. My colleague and copresenter is Mrs Connie Smith, and she'll follow my particular presentation.

The Ontario Palliative Care Association welcomes the opportunity to present its views with respect to Bill 173, the Long-Term Care Act. The association has been in existence for 10 years and is composed of a membership of over 400 individuals including nurses, physicians, volunteers, social workers, therapists and clergy who work in or have had experience in palliative care. The interdisciplinary nature of the association brings many perspectives on the care of the dying.

It is the belief of the association that palliative care should be accessible to all individuals faced with illness no longer responsive to curative treatment; considers the physical, spiritual and psychosocial dimensions of that person; provides support for the individuals and families facing death and bereavement; and is interdisciplinary in its nature.

The association is governed by an elected board of 12 directors and these directors come from 12 different regions of the province. We do have consumer representation and we also have cross-board appointments.

The Ontario Palliative Care Association's mission is to be a supportive forum for its members and to be a coherent voice for palliative care in Ontario. The goals include support to its members, and encouragement of the development and expansion of palliative care and services in this province. The association attempts to achieve these goals by providing education and developing opportunities, by facilitating communication and by acting as liaison between local, regional, provincial and national palliative care providers.

The association has welcomed the many opportunities to participate in the extensive public consultations. We have been very encouraged to see that the reform reflects the issues and concerns raised by this association. We have been very actively involved in the provincial palliative care initiatives, having representation on the

working groups and on the steering committee. Our members are continuing to be involved at the regional level, planning palliative care education for physicians, community service providers and volunteers.

On behalf of the association, I wish to comment on several sections of the bill. I'd like to start with part II, "Interpretation."

Professional services: The inclusion of social work services and dietetic services as criteria services will now allow for greater flexibility in meeting the needs of palliative patients. As well, the enhanced funding package will add flexibility to better plan for these individuals.

1710

The Ontario Palliative Care Association supports the bill of rights. Many of these rights form the foundation on which palliative care is built. The right to be treated with courtesy and respect, to promote autonomy, to allow for dignity and privacy, to recognize individuality and respect cultural, ethnic, spiritual, linguistic and regional differences are all fundamental to the provision of palliative care.

Part VI, "Multiservice Agencies," the limit on purchased services: This is an area of concern for OPCA. There will be members of our association who will be affected by this decision. Many of the private sector businesses were established because it was recognized that in several communities the services needed were not available to palliative patients and their families. Patients were not being given the opportunity to remain at home for their final days or to die at home.

These businesses recognized that our present system was lacking and filled the gap. They will suffer because of the 20% decision. Whether palliative patients and their families will suffer I think is an ongoing question.

With the enhanced service package, we will still not always be able to provide enough service to meet the needs of some palliative patients. If these small private agencies are forced out of business, will the consumer have the opportunity to purchase privately?

This brings another question: Will the MSAs sell their services privately? Patients and families with private insurance coverage frequently use this to top up the service packages provided. If purchasing from an MSA is not an option, continuity of care will be compromised.

Part VII, "Rules Governing Approved Agencies," the development of a plan of service: Assessing the person's requirements, determining their eligibility, developing a plan of service, and revising that plan of service are all key elements to the successful management of a palliative case in the community.

Determining the palliative patient and family's needs, respecting their physical, psychosocial and spiritual needs, establishing a goal with them and a service plan to meet that goal requires skilful case management. It requires sensitivity to the patient and family's emotional state. Here we need to look at where the family is at with their illness, where they see themselves, not where we'd like them to be. Good grounding in palliative care education is essential.

The provision of palliative care in the community is

both demanding and rewarding. It requires a team approach. Community service providers often work in isolation and case managers often are looked to for emotional support by members of this team. Skilled case management is the glue that holds the palliative care team and the community together.

Part VIII, "Rules Governing Service Providers," access to personal record: In regard to the person's right of access to their personal record, it has been clearly identified that transfer of information and access to medical records is often a barrier to the provision of palliative care. Palliative patients see many health care providers through the course of their illness and undergo many procedures and treatments. Repeating their story to each new provider they encounter is a great frustration and a burden.

A travelling chart that belongs to the client, with their own history and their own treatment plan, is currently being developed in several communities in Ontario. The information in this situation now belongs to the patient, and they choose whom they will share it with. This approach supports patient autonomy and control.

Part IX, the appeals process, application for review: There are two points to be raised in regard to the appeals process. With the present system of service provision in the community through home care programs, additional supports are not provided, for example, from insurance companies until home care has reached its maximum level of service.

It has been brought to the association's attention on a number of occasions that additional supportive programs would like to become involved, for example with AIDS patients, but, in accordance with their program guidelines, they must wait until home care provides a maximum level of service. They often wish to challenge home care service plans. They'll encourage the clients themselves to challenge this, and I wonder if there will be a mechanism to deal with this.

Also, as mentioned previously, there are problems with insurance companies. Approval of additional services to be paid for through insurance companies is becoming increasingly difficult to obtain, to the point where many patients die before approval is received. I wonder if there will be anywhere in the act where this will be addressed.

By having an appeals process in place, it is hoped that the provision of services for palliative patients will become more uniform across the province. In other words, I'm hoping that it will have a positive effect, because we've heard over and over again where there are variances within case management areas and variances within programs, and I hope by having the appeals process, we'll see a positive result.

Finally, I'd like to talk about respite and choice. There is concern within the field of palliative care that with the redirection and reform, palliative patients and families may be forced or pressured to care for their loved one at home without access to respite or designated beds. There are palliative patients who lack the supports needed to maintain them in the community. For these patients, there must be options.

In conclusion, the Ontario Palliative Care Association, representing a diverse group of people who provide hands-on care and support for patients who are terminally ill, supports the redirection of long-term care. We support the basic respect for human life and dignity through the provision of excellence in care for the whole person and his or her family as the end of life approaches. This time presents many challenges to the care providers and society to meet the myriad of psychosocial, spiritual and physical needs of these individuals. Society needs to rise to the challenge, and government can take a leading role to ensure that appropriate care is available to all those suffering the ravages of terminal illness.

I'd like to turn it over to Connie.

Mrs Connie Smith: Good afternoon. I'm Connie Smith, vice-president of the Ontario Palliative Care Association. In conjunction with my colleague, I would like to comment on several issues: one-stop access, community, continuum of care and volunteers. I do commend government for a policy on palliative care in December 1992 and the inclusion of this provision of care in long-term care redirection.

Mr Chairman and committee members, the Ontario Palliative Care Association, as you've heard, represents the hands-on providers of palliative care in Ontario. We believe palliative care is an essential part of long-term care. Bill 173 creates a framework for long-term care. The association played a key role in the provincial palliative care initiatives and our members continue to work through the implementation at the regional level.

Throughout this process, the consumer voice was clear that ease of access was a priority for persons in need of service. Therefore, it is without hesitation that we support the concept of one-stop access.

Bill 173 is addressing community long-term care, excluding institutions, which suggests legislators and policymakers do not have a clear vision on the continuum of care. Consumers and providers alike define community and home as, "Home is where the patient currently resides." We must address the concerns regarding patient-client choice and the need for respite care. There is a growing concern that patients, clients and their families will be pressured, if not coerced, into providing care to the terminally ill at home. With shorter hospital stays and the nature of acute care facilities, it is clear beds will be limited. We believe long-term care facilities, including chronic care beds, have an important role to play in the provision of palliative care. There are palliative patients and clients who choose institutionalized care for a variety of reasons, and this must remain an option.

Let us look at a small Ontario community's experience in palliative care to date. This model is providing excellence in palliative care to the community residents. The home care provider contracts in-home services for patients and clients in the community based on client-centred care planning. The case manager is a member of the hospital palliative care team. Volunteers coordinated by the hospital provide support to patients and their families in hospitals, long-term care facilities and homes. The palliative care team provides 24-hour-a-day, seven-day-a-week available expertise to hospital staff, long-term

care facilities, patients, physicians and community agencies. Respite and admission to chronic beds are available to patients and families as required. Can we be assured this choice will remain?

We must ensure Bill 173 does not deny any community to respond in an innovative way to meet the challenges of palliative patients and their families. We must foster and encourage the volunteer members of palliative care teams, because they are the link that reflects the dying person. The bill of rights must be the foundation for the vision of long-term care and its future direction.

In conclusion, the association supports the redirection of long-term care in ensuring patient/client-centred care for the terminally ill.

1720

Mr Wessenger: Thank you very much for your presentation. I certainly appreciate it, and certainly some items have been raised that haven't really been raised before. Perhaps we could explore some of these recommendations.

First of all, you raised the question of the MSA selling its services privately. You indicate you wish to see that power to be there, and I can indicate to you that the legislation does permit that, but do you see any downside to an MSA providing services privately?

Mrs Douglas: If I can respond to that one, if MSAs don't provide the service, then it doesn't leave individuals who want to top up what their service plan is, to expand—they're not going to have continuity of care. You're going to bring someone from a private agency into the situation where they're already used to the service providers who are in. You will lose your continuity of care. I see it as a positive move, so that they can expand on the service plan given to them.

Mr Wessenger: And you don't see any negative impacts?

Mrs Douglas: No.

Mr Wessenger: The other point you raise is the whole question with respect to the right of access to medical records. As you know, it's provided in the bill that the person will have a right to the information with respect to their own medical information. But I'm wondering, do you feel this right to access should be expanded, for instance, to allow the sharing of information between the providers without the necessity of going back to the consumer for their specific consent?

Mrs Smith: I think the association has addressed that in what we see as some pilot projects in the travelling chart, and I think as long as we give ownership to the client or their designate, then in fact they're free to share that with anyone they choose. But we certainly don't look to one consent and information-sharing across the board without really informing clients.

Mr Wessenger: Yes. Could you perhaps give a little elaboration about this travelling chart, some more information? I'm sure members of the committee would appreciate a little more detail on that, where it exists and how it works.

Mrs Douglas: I'm actually sitting on a committee now that's developing a travelling chart and I'm also on

the provincial cancer network and sitting on the supportive working group where this idea keeps coming up over and over again, but it has over the last several years.

An example of an individual who needed such a thing as a travelling chart was an oncology patient who came to my area on holidays for two weeks, didn't have a physician in our particular region, got into difficulties with bleeding and needed to go to hospital. Now, what kind of records does she have? How do you ship her off to the local hospital and say to the physician: "Here you are. We've accepted the responsibility for care of this patient in our community, but we really don't know a whole lot about her." She, very nicely, had a travelling chart from the oncology clinic in her purse. So she was able to present that to him, which gave him information as to whom he should phone, what clinic she was attending, what treatments she had already had, what x-rays she'd had. He called the clinic and was able to speak with the oncologist and they told him immediately what to do, and the patient was treated, released from hospital the next day and returned to her vacation in our particular area. That's the kind of information we're looking at having patients have access to, so they can then take the information to people they want to share it with.

When you get into sharing all this information between agencies and between volunteer organizations, the mechanism of doing so and the barriers become insurmountable. So if the patient owns it, the patient loans it, and that's the way it goes.

Mr Wessenger: So you think that's the best way of dealing with the information?

Mrs Douglas: Well, it's a way around a whole lot of roadblocks.

Mrs Smith: I think our consumers tell us over and over again that—certainly, palliative patients find that one of the most distressing things they're faced with is telling their story time and time again to care providers. If we truly are listening to our consumers, we have to look at innovative ways to meet that need.

Mr Wessenger: Right. Thank you. I appreciate that.

Mrs Sullivan: I'm going to follow on that same point with respect to the records. My sense is that the travelling chart isn't in fact the full medical record, and so there's a little bit of a difference here from what, by example, we were discussing with the consent to treatment bill provisions.

The diabetes association, I believe, has introduced a travelling chart—

Mrs Douglas: Right.

Mrs Sullivan: —which is highly effective in providing coverage, and once again the patient has the control over sharing the information. One of the things I would caution about and that I wonder if counsel would look at are the provisions in the bill of rights with respect to medical records.

In the Consent to Treatment Act we took into account some highly professional testimony which indicated that for some people at certain times, access to their own records can cause a setback in the course of their treatment and their response to care. I'm just not certain if

those provisions have been adequately transferred into the bill of rights as it's proposed in this legislation, and I think counsel should have a look at that. I think your idea of the travelling chart probably doesn't need legislation; it simply needs the will to put it into practice.

Mr Jim Wilson: Thank you for your presentation. I too had circled some of the stuff that Mr Wessenger already covered with respect to MSAs; for example, providing private services. I hadn't thought of that one either. If there are no private sector agencies around—

Interjection: What are you going to do?

Mr Jim Wilson: —and there's no public sector or non-profit agencies around, it all comes down to the MSA having to provide it. It's something we'll certainly have to look after, although I don't see anything prohibiting that in the act. I think that was Mr Wessenger's point, but as with all points that are given to us, we will double-check that.

You've a very good sentence here that talks about "There are palliative patients/clients who choose institutional care for a variety of reasons and this must be an option." I'm a little surprised at your fairly strong support of this bill. If you take this bill with its companion legislation, Bill 101, if you look at Bill 101 and all the criteria that must be met to get into an institution, to get into a nursing home—and remember, there's a bunch of new criteria and hoops that have to be jumped through before you're even considered to be on the waiting list to get into an institution—one of those is that all other options have to be explored in your geographical area, so I assume within the MSA.

I think one of the problems with this bill and it may be putting out a bit of false hope, but I hope I'm wrong, is that the bill talks about these baskets of services that are going to be available, but because we don't know what kind of dollars this is backed up with, it may be that the government will deem in your area of the province that people can't go into nursing homes, because when they try and get to that "all other options criterion," they look and they've got an MSA and the government looks at its books and says, "That MSA has all of these things available."

I guess what I'm trying to say is that the two bills working together make it extremely difficult, I think, for someone who may choose, for whatever reasons, to want to be in an institution. The whole thrust of this thing is to keep people in their own homes. I can tell you that in my area of the province—I remember when the government went around with its road show on the consultations on redirection of long-term care, and I told this story last year—at the Simcoe Manor in Beeton, for instance, I had two ladies come up to me after they had witnessed the dog-and-pony show and say, "My God, does that mean we have to move out of this place and go back home?" They didn't meet any of the criteria. They were fairly well individuals, on the surface anyway. I said, "No, I don't think so." They said, "Good, we've peeled enough damned potatoes."

They were just perfectly happy being in the Beeton manor. That's where you want to go in my area; it's tender, loving care. I should say that because my aunt is

the head of nursing there. We have palliative care teams and it's a wonderful place and it's where you expect to go, but you can't get in any more. If you go to the letter of the law when this comes in, it's going to be very difficult to get in, because the government's going to say, "Those services are available in your area, Mr Wilson, and I suggest your constituents use those services."

Mrs Smith: I think I can speak with some clarity to that issue. I also discharge-plan at a small community hospital. I think we have just seen placement coordination service come into our area. So far I see some very standardized assessment tools being used and I see that as positive. I think there are other alternatives, as far as institutions, as nursing homes are concerned. I think nursing homes and chronic beds provide a higher level of care and a level of technical expertise that may be necessary for palliative patients. But generally speaking, I think if folks don't meet those criteria, there are other institutions that are available to them, lodge settings and that. I simply don't think our system can support folks in high-cost facilities unless they need the service.

I certainly, from a discharge planning point of view and an institution bias, support standardized assessment tools and feel that folks need to be where the level of service can be maintained.

1730

VICTORIA COUNTY COMMUNITY CARE

The Vice-Chair: The next presentation will be made by representatives of Victoria County Community Care. Please introduce yourselves and proceed with your presentation. Welcome to the committee. We apologize for the lateness of the hour, but you'll see the keenness the members have for this particular bill.

Mrs Val Barkey: We appreciate the opportunity to be before you here today. I'd like to introduce to you Peggy Long who's the chair of Victoria County Community Care, and I'm Val Barkey, the executive director of our agency.

I believe most of you have before you a script that we'd like to utilize; however, we'd be pleased, if any of you would like to stop us at a particular juncture, to do so. Obviously, there has been a planned format for questions, but I certainly invite that as I go through the presentation. I won't read it in its entirety, so if you think I've skipped a spot, yes, I have, but intentionally to hopefully address the issue of brevity.

Victoria County Community Care is a community-support service agency which has been providing a range of services for the past 10 years to seniors and people with special needs. Approximately 55 administrative and service staff and 400 volunteers combine their talents and expertise to improve the health and quality of life for Victoria county residents.

This represents nearly 48,000 hours of volunteer time, contributed last year alone. Peg Long, accompanying me here, was a major contributor to that total volume of hours. I know she'd be please to respond to any questions you might have with regard to voluntarism.

After so many years of contemplated reform, I'm sure we're all pleased to see the recommendations formalized

in draft legislation. We must resist the urge, however, to speed to a conclusion without a sure sense that the proposed legislation will indeed create a preferred world. Essential elements in that preferred world are:

- Reduction in the number of agencies and workers providing service to an individual client achieved through the integration of case management and service provision and the merger of agencies.

- Single source for information and assessment services.

- Adequate, flexible funding.

There are, of course, additional important elements as well and these include:

- Much greater integration of housing and recreational initiatives with health and community support services. Seniors' needs will only be met if there is a continuum of service available, from recreation and leisure needs of healthy, active seniors to the heavy care needs of the frail elderly. Commitment to real collaboration and a continuum of service delivery begins with leadership and tangible action from Queen's Park.

- Enhanced care giver support program development based on a greatly restrained reliance on families as care givers.

- Continued collaborative involvement of client and community in the design and implementation of needs sensitive services.

- Quality management systems.

Clearly, the greatest concern has surfaced over the issue of implementation. What needs to be done is always easier to describe than the how. The following is Community Care's response to Bill 173:

To purpose 1(a), we say: The government cannot ensure that many services dependent on volunteers will be available in rural areas.

To purpose (b), we say: How will the act improve quality? As a result of standards? Quality care is not merely a result of achieving standards. Integral to quality health services is a caring, compassionate attitude. The positive effects of soft, qualitative contributors on the healing process are well documented. Legislators must remember that conformance to standards does not necessarily result in healthy bodies or minds.

To purpose (c), our agency responds: To recognize the importance of a person's needs and preferences is clearly a worthy goal, but may we remind funders that the creation of site-specific care plans requires time and the commitment of funds to support this process. If the government is not going to increase funds for service planning and coordination which is sensitive to client preferences, then don't include 1(c).

To purpose (d), we say: amen, but do stop at the provision of the framework. Allow communities the ability to develop within defined parameters a system which responds to local need.

To purpose (e), we say: Legislators are wise to recognize that their responsibility is the promotion of equitable access to services and thereby achieve at least a modicum of justice. However, I sound a cautionary

note. Having been involved in the development and delivery of community-based services in Victoria county for 10 years, I am convinced that the strength of this sector has been its ability to respond to need when rules and regulations of the traditional health care system failed.

Whether trying to coordinate ongoing transportation for a dialysis client or respond to issues of elder abuse, community-based services have been able to meet need because they were willing to go beyond the health care units, which often maintained that such needs were not within their mandate. Furthermore, I challenge legislators to recognize that access in rural areas goes beyond eligibility criteria and uniform rules and procedures. An infrastructure must be developed which recognizes the unique requirements of rurality and minimizes nature's access inhibitors.

Primary focus must be given to the issue of transportation, minimally addressed in part XI, section 51 of Bill 173. Rivalry between the ministries of Transportation, Community and Social Services, and perhaps latterly now long-term care reform, over mandates must be laid to rest. Local municipalities simply cannot be vested with the total authority to determine whether transportation for their citizens will be provided. In rural areas, where distance increases transportation costs, there must be a funding formula which neutralizes this factor if the government is committed to the concept of equitable access.

This is of significant import for so many programs. As we urge focusing on the general issue of nurturing a requisite infrastructure to support long-term care reform, and specifically on transportation, may we also encourage continued review of the misuse of ambulances for non-emergency transfer or physician appointments of clients in long-term care facilities. The Swimmer report of 1991 on emergency medical services must be considered when addressing the issue of reform and the provision of a continuum of services.

To purpose (f), we say: Who can argue with this purpose? Certainly not community care. However, there must be thorough and careful thought given to the measurement of efficiency. Agencies such as community care would welcome the input of those who could assist us to increase efficiency. However, when we still spend so much time trying to get volunteers to provide daily secretary-receptionist support or to carry out fund-raising, the issue of efficiency becomes academic.

A difficulty when measuring efficiency results from the significant variation of inputs. For example, to coordinate and arrange friendly visiting services for a client takes significantly more time than coordinating or arranging for Meals on Wheels service. If we measured the efficiency of an agency by units of service outputs, there may be a tendency to provide only those quick-fix, high-volume services because of the positive effect on the bottom line. There must be a heightened commitment by government to develop appropriate funding formulae if purpose 1(f) is to be fairly achieved.

To purpose (g), we say again, like purpose (f): The intent is laudable and necessary. Clearly, these are

requisite functions in a reformed world. Perhaps the operative word is "encourage." The dictionary defines "encourage" as "to assist, to hearten, to inspire, to stimulate, to foster." Therefore, the purpose of this act is to positively nurture the listed functions.

May we indicate that no amount of legislation will inspire or stimulate unless it is developed with the recognition of the investment in human resources that these functions will require. If there is an expectation that community-based agencies and volunteers will continue to meet service demands while at the same time undertake these human resource consuming functions, we can anticipate failure. Collaborative planning and integration assistance will require a further human resource commitment. It cannot come from existing staff. Nor can we continue from one stop-gap employment grant to the next. There must be a tangible commitment of human resources to achieve the ideology of purpose 1(g).

1740

Perhaps we could proceed now to the definitions. Generally, the definitions are clear. Predictably, though, there is still some concern over what constitutes an agency and whether the definition excludes a federated system in favour of a formal, legally created new entity. Perhaps greater concern resides with the implementation of the new definitions. Certainly an adjustment period for the education of both the public and staff will be necessary. Furthermore, if, as anticipated, the definitions are used to determine eligibility for funding, it is of utmost importance that the legislators consider the procedural or implementation challenges resulting from the definitions.

Also, our agency registers concerns that there is no clarification regarding supportive housing and attendant care services as components within the designated service pockets. Fragmentation will continue to be perpetuated until these services are considered within the context of the whole long-term care reform initiative.

Proceeding to part III, bill of rights, this part demonstrates a sensitivity to a broad variety of needs and yet one harbours a concern in terms of its application in rural areas. What is meant by the word "ensure"? Does it mean in rural Ontario, if our agency receives a request for a friendly visitor of a specific ethnic nationality, that it would have to ensure an ability to find a friendly visitor to match the request? Again, I suggest judicious use of the word "ensure" as it relates to rural Ontario and to those services provided by volunteers.

Part IV, dealing with directors and program supervisors' appointment, we respond: Historically, the word "appointment" has elicited both positive and negative responses. An appointment based on merit, free from partisan politics, is indeed an honour. Regretfully, though, we are all too familiar with appointments based not on merit but on patronage. If we value accountability and effective resource utilization, the yoke of patronage appointments must be lifted.

Part V, dealing with funding approvals: We suggest there is good flexibility demonstrated here. We question, however, the comfort level of volunteers who under section (a) could potentially work directly for a minister. A key concept in the management of volunteers is

recognizing the satisfaction derived from making a positive difference in their local communities. Even though volunteers derive intrinsic satisfaction from service, funds must be invested for recruitment, training, scheduling, supervising and recognition as well as for expense reimbursement.

Regarding subsection 8(2), the agency applauds its inclusion. This clause is particularly important in rural areas where satelliting of local offices has proven a very effective method for service delivery. Continued advances in electronic technologies make the inclusion of this section even more appropriate and necessary.

Part VI, dealing with the multiservice agencies: As we all know, this is where the storm seems to reside. We acknowledge with appreciation the many hours of thought and study that have preceded the formulation of legislation governing the multiservice agency. We have responded with many others and we feel in terms of our perspective the following are the non-negotiables:

—Flexibility with regard to the geographic area served based on genuine community input, not driven just by the traditionally strong health sector.

—A full continuum of services must be available. Therefore, we suggest the exclusion that is allowed for in section 15 be eliminated.

—Full public disclosure regarding the decision-making process for the selection of the MSA, particularly if a health unit or municipality is selected. The minister must be held fully accountable if either of the above options is selected.

—Comprehensive information and referral. This service has traditionally been a funded home support service and we've witnessed its exponential growth in our county and we certainly feel this is one of the very essential elements that an MSA can offer. We've been able to produce as well as providing our 1-800 number some service directories which we offer to show you today and these have provided a very valuable service. So we certainly support strongly the recognition that information and referral must be enhanced.

May we again emphasize that if legislation does not merge community support with personal-support professional providers, the government essentially will have maintained the existing status quo or perhaps have exacerbated it. A potential wedge may be driven within agencies which offer personal support and homemaking services as well as a range of community support services. Energies must focus on achieving the goal of reduced service fragmentation while maximizing client access.

Part VII, rules governing approved agencies: It's generally straightforward here and listed by sections. Perhaps, though, we will just underscore some difficulties. I'll draw your attention to section 23. This clause will render section 21 virtually impossible to achieve. I'm sure you're familiar by now with the bill, but you might find it useful to refer back. I refer to the impossibility of providing written notice to a client for every service provided, which is currently proposed in the legislation.

May I illustrate with the provision of transportation

services in rural areas. Client A might call the MSA to arrange a ride in a locale 20 kilometres away. The volunteer proximate to the client is contacted and a ride arranged. Now, how will that client be given the notice? Obviously, you cannot ask a volunteer to pick up the notice, or should you automatically allow the volunteer to carry blank forms with them in the car? If the computerized system is in place, this can present difficulties in returning the form back to base.

So often a service is needed and time does not permit delivering written notice of service. Last year we provided almost 100,000 units of service. If notices had to be given to all those clients, I'm sure we'd still be inundated and probably not even a third of the way through. That's not to reflect inefficiency on our part but just to indicate how much administration would be required if that clause were in effect. We urge the government to demonstrate common sense and a respect for practicality.

Section 24: Community Care is pleased to see the inclusion of this clause. Over the past 18 months, our agency has piloted the development of a continuous quality improvement program for our sector. This manual is the culmination of that project, entitled Integrating Quality Within Your Organization. Our agency is certainly committed to this concept, and it was demonstrated in our distribution of it to our members in the community support sector. We're not afraid of being required to operate and to demonstrate quality.

With regard to 25, despite the brevity of this clause, the issue of client contribution for service has been the subject of lengthy debate and wide polarity of thought. It has been our agency's experience that most clients are willing to contribute towards service provision. You may be interested to read of Community Care's experience with the provision of respite care. I won't read it for you, but it was an interesting experiment, and we certainly support the fact that service can be offered on a fee-for-service basis. Given our country's current economic malaise, we may look more intensely at cost-sharing arrangements for service provision.

Part VIII, rules governing service providers: Community Care recognizes the necessity to allow for the provision of purchase-of-service agreements. However, there is concern with regard to the increased costs inherent with purchase-of-service agreements and with regard to the establishment of fair and appropriate rates for the purchase of service.

There's an illustration there of the significant variation in input costs and how difficult it is to establish what is a fair rate, particularly in rural areas, when the factor of transportation must be addressed.

Generally, we would discourage the practice of purchase of service as much as possible so that a continuum of services can be provided under a global budget by one agency. Research tends to support this approach. There have been two good studies done, one by Rick Zawadski and Catherine Eng in their paper Case Management in Capitated Long-Term Care, 1988. They cite the finding that the "consolidated model actually proved less costly when the additional communication costs associated with

service planning reimbursement and client monitoring were considered." Catherine Hennessy also addressed this issue in her paper, Modelling Case-Management Decision-Making in a Consolidated Long-Term Care Program, 1993. She provides a very interesting assessment of case management decision-making. It was found that generally the range of case managers had a "conservative approach to care planning. The most expensive and intensive plans were used sparingly." Balance represented by a good cross-section of health and social services may reduce the frequent knee-jerk reaction for a quick health fix.

It might be prudent to stop now and invite questions from you, if you'd like. The remaining parts can be read by yourselves, if you so desire.

1750

Mr Jim Wilson: I would just like to tell the presnters that Chris Hodgson has used you as an example in our caucus on several occasions of how things could and should be done. In fact, although I'm Health critic, I think Chris would like to be Health critic because he's had a lot of experience on health boards and with district health councils and with groups such as yours.

I do have a question, though, on page 22 where you're talking about purchase of services. Perhaps it's the time of day or something, but it seems to me that your argument is that it's better to do these things—I'm not sure what your argument is on pages 21 to 22 with respect to purchases of service.

Mrs Barkey: It's a good thing I didn't become a lawyer, isn't it? My clients might be in trouble.

Mr Jim Wilson: Do you want to make the point? While you talk about the cost of Meals on Wheels, I guess you're saying that some of the larger players are able to get a lower per-unit cost.

Mrs Barkey: What I'm trying to say is that inherent to purchase-of-service agreements is a significant amount of administration, which results from a complete separation of the contractor to the service provider, so you have to follow requests with a significant amount of paperwork, contractual work, and usually—I know home care has to have lawyers review the service contract with other organizations. What we witness is that when home care, which is usually the purchaser of service, would purchase a service, there are these inherent costs that agencies have to absorb—home care probably has to absorb some as well—and they tend to augment the cost of service provision.

To introduce the other part of the equation, though, the cost charged for a unit of service doesn't always necessarily reflect the cost. That's why I give the example that for us a Meals on Wheels might cost in one area \$10 and in another \$4, but we get \$5.25, so where does the other money come from: my fund-raising volunteers? Or how can we supplement that? And I suggest there are other hidden costs that still haven't been factored into that actual unit cost.

Mr Jim Wilson: How I thought that might roll into 173 is that I think—and I might be wrong—the government wants to set rates, particularly the rates that will be

charged to consumers directly, the user fees. For example, there was a suggestion by Dr Greengarten from Baycrest that they would like some flexibility in their own area to not see a standard rate for services across the province but to be able to set different rates.

What I got out of that and what you've said—I mean, your costs in a rural area may be higher than downtown Toronto to provide Meals on Wheels, and if the government sets a flat rate of \$7 or something per meal, that may not actually cover your cost. Is that a concern there? There is the request before the committee to try and introduce some flexibility in the language of the bill so that local MSAs can perhaps set their own rates and their own charges to consumers.

Mrs Barkey: I think your summary is quite accurate and appropriate. Throughout our response, we've tended to use the words "flexibility," "framework," those words that do allow for a community to plan. While I recognize that sometimes that might be interpreted as inconsistency, we have to recognize that there are significant variations, from our perspective particularly brought about by rurality, that we must allow for in the funding formula.

Mr Jim Wilson: With all the discussion going on in Victoria county, do you have a good idea of what the MSA is going to look like? And how does Community Care fit into the new model? You're actually on the leading edge of some things. I'm just wondering how you're coming along with your MSA.

Mrs Peggy Long: Very slowly. I don't feel that we really do.

Mr Jim Wilson: You don't feel you really do fit in?

Ms Long: I hope we would fit in, but I'm on the planning committee and I feel it's very slow and there's a variation of ideas as to what an MSA will look like.

Mr Jim Wilson: So you don't know any more in Victoria county than we know here.

Mrs Barkey: Again, we really would appreciate if we could have flexibility, from a significant amount of connections electronically to a full merger. There has to be some happy consensus, maybe some way in between. Our palliative care Saint Elizabeth persons talked about those really strong feelings of community that are attached to many of these agencies, and we don't want to be unmindful of those. But I think there's much we can explore to prevent some of the fragmentation that exists now. Just electronically we can do a lot to improve the way we do business.

Ms Carter: I'm not the member for Victoria-Haliburton—of course that's Chris Hodgson—but I am next door in Peterborough, and I believe as far as health services go there's quite a lot of overlap, so I certainly feel this is kind of home. Apparently Chris Hodgson used you as an example of how things could and should be done, and I think that's wonderful because I feel the same way. I would go a little further and say you're almost a preview of the kind of thing we're getting into with this legislation, because you are a county-wide organization, formed, I believe, from the amalgamation of several fragmented community support providers. Yet the fears we've heard expressed here about caring disappear-

ing when we get this kind of amalgamation, that this flexibility, this concern for the individual consumer would disappear, doesn't seem to have happened in your case; in fact you seem to be a shining example of that.

Also, you still manage to attract volunteers. We're told that once we lose the ethnic or religious or whatever it is specific organization, volunteers are going to lose interest and they're not going to want to serve any more. How do you have such success in attracting volunteers?

Mrs Barkey: I'm not sure if we owe our good start to Geoff Quirt, who was my first program supervisor, but nevertheless we do consider the fact that in a microcosm, we do demonstrate a small MSA. We range from professional services, we have nurses working for us, health care aides, and we have volunteers. I think it results from being able to skillfully use people where they fit best.

Peggy, as a volunteer, if I can use her as an example, has a wealth of talents, which have ranged from producing our newsletter to chairing to being an outstanding support in the development of a rather unique program, our in-home respite care unit, a converted apartment unit which now provides seven-days-a-week respite care. Those sorts of things are a demonstration, I think. When you match people with their areas of skill and expertise, it's phenomenal what can happen.

I do harbour a concern, if there is strong unionization, that some of the ability to utilize volunteers in areas might be diminished, so I would hope that an MSA will never be a place where we cannot have the full opportunity to utilize volunteer skills.

Ms Carter: That's our intention too.

I think it's fascinating too that you're saying that the practice of providing services under a global budget by one agency is efficient. We've been sitting here saying that, and we've had so many presenters who have been contradicting that and saying that to have one agency coordinating and assessing people and then giving out the services to contract service providers is just as efficient. We're saying there are gains by having it all together in one organization, and you have very positively shown that it works in practice and that it is the case.

Mrs Barkey: The key thing is that it works for the client. At least two calls a day we would get from clients who are confused because they don't know which agency they should contact. Admittedly, with our name being Community Care it is somewhat confusing with home care, but if we work from that point of view for the clients, that they know one coordinator is looking after it, whether it's transportation, whether it's the respite care they need or whether it's the Meals on Wheels program, that person does in fact have a comprehensive knowledge of their needs and can dispatch either volunteers or paid staff to be a part of that. It's worked for us. I'm not suggesting that we know it will work for everybody, but certainly in our county we've seen that that ability to have a continuum within our own structure works.

1800

Mrs Sullivan: There are a couple of things I wanted to raise. The first is a question of the parliamentary assistant with respect to the government's intentions re

attendant care. Yours is the second brief that has raised the issue of attendant care and supportive housing. I understand why supportive housing is not included in this bill, but the attendant care issue is one that—I would just like confirmation that attendant care would be covered under personal support services under routine personal activities of living and assisting a person with those activities.

Mr Wessenger: Yes, you are correct.

Mrs Sullivan: So we can pass on to organizations that attendant care is in fact covered by the bill.

Mr Wessenger: Mr Quirt would like to add something.

Mr Quirt: If I might just add a clarification, as a result of concerns expressed by the community of people with physical disabilities during our consultation, we've offered each group of clients from each attendant care outreach program we fund separately the option of, community by community, deciding whether they'd like to see their attendant care outreach services delivered by the multiservice agency staff or whether they'd like to see the province continue to directly fund their separate attendant care outreach program. It will be a decision made by the local consumers as to whether or not they receive their services from the MSA or from an independently funded organization. The eligibility criteria for the new basket of services delivered by MSAs would include the right for an MSA to deliver up to attendant care outreach levels of service for other clients who met those eligibility criteria.

Mrs Sullivan: The other issue is the one of transportation. You're the first group that's raised that as a problem. In the communities I've been in, I see transportation as a major problem, and the shift to the MSA is even more difficult. Transportation issues aren't easy. First of all, there's the disabled transport, which is in many communities handled by a municipality as part of its regional or municipal transportation system. In other communities it's a contracted service from the council. That's one type of transportation service. Then there's the volunteer transportation service to ensure that the person is taken to a treatment place or a respite care centre or a social activity. Then there's the more intensive transportation needs where a patient may be taken, by example, to and from chemotherapy services, where you want a higher level of skill associated with that transportation.

You talk about the rivalry between the Ministry of Transportation, Comsoc and Health over mandate. I'm not sure what those traditional rivalries have been, but it seems to me that if transportation in a generic sense is a required service under the bill, the government had better be very clear about the limits it wants to take transportation to, what it includes in transportation services the MSA has to provide. Otherwise we're going to see MSAs taking over every municipal disabled transportation service along with all sorts of other volunteer services that are now operated, and we will indeed approach the regional government size and reach that Mr Wilson spoke about earlier.

Mrs Barkey: I appreciate your understanding that transportation affects many programs. You think of adult

day programs. In our rural area, just driving a distance certainly impacts on those who can participate because they have to pay both for the transportation.

In the current legislation, if a municipality wants to provide transportation, it can. As you can appreciate, with increasing costs not too many municipalities, if they don't have a program for the disabled, want to incur those costs. In our particular community there was not funding through, first of all, Community and Social Services or, latterly, long-term care for the provision of transportation, so we were able to manage, without any contribution from the municipality, to operate a van program, but we were only able to manage because we had service clubs get behind it, because we've had fund-raisers who got behind it and because we've had the ability to access a federal grant for conversion of the van—those sorts of things. There just seems to be not a real sense of commitment to the urgency of transportation needs in rural areas.

I think you're right. Clarification is definitely going to be needed over whose mandate it is and whether others can kick in if that one stops, but certainly there must be a recognition of how important it is, and also in delivery of the services, the cost of delivering the service.

Mrs Sullivan: There's another issue associated with transportation that my colleague Steve Offer has raised in the House on a couple of occasions. It certainly affects my riding and the Mississauga ridings and I assume other areas of Ontario are affected; that is with respect to the licensing laws associated with the services being offered, frequently a taxi service or a transfer service, whereby the municipal licences that go to the edge of the boundary mean that a car or a vehicle which takes a person for treatment in Toronto can take them there but they have to be taken by a Toronto vehicle to the municipal boundary and then picked up at the municipal boundary by the Halton or Peel vehicle. That kind of nonsense has created havoc.

Mr O'Connor: That's the taxi licensing.

Mrs Sullivan: It's partly taxi licensing, but it's also the transfer services, I suppose, that are contingent.

Mrs Barkey: You're right. That's the kind of issue that's important to address.

Mr Wessenger: I'd like to clarify. First of all, if we look at the bill, when we talk about transportation services we mean providing transportation to persons who are unable to use existing transportation, so it's really where there's not an existing transportation system that the person's able to use and where there's the provision from the MSA. With respect to that problem of cross-boundaries, I believe it is solved in the legislation. Perhaps legal counsel could indicate the section.

Ms Czukar: It's the Public Vehicles Act exemption in 51. That says the Public Vehicles Act licensing requirement doesn't apply to vehicles that are being used by approved agencies to transport people who are eligible for those transportation services under that exemption. That's to apply to situations where agencies have a van or operated service of some kind and they've been challenged in the past by commercial providers. Often it's such a significant challenge that they park the van and

don't provide the service, because the prospect of going through the hearings to obtain a licence and so on is too intimidating. So we've tried to deal with that issue, but I'm not sure it solves the problem of the taxi licensing.

Mrs Sullivan: Exactly.

Mr O'Connor: That's covered under the omnibus bill that's before the House right now. It's in there.

Mrs Sullivan: We'll support it, then.

The Vice-Chair: With that, the committee, at this late hour, will recess until approximately 7 pm. Members and staff are invited to supper in room 228.

The committee recessed from 1810 to 1906.

SENIOR PEOPLE'S RESOURCES IN NORTH TORONTO

The Vice-Chair: Good evening and welcome to the standing committee on social development, presently holding hearings on Bill 173, An Act respecting Long-Term Care. The first presentation will be made by representatives of Senior People's Resources in North Toronto. Welcome to the committee. Please introduce yourselves and proceed with your presentation, and if there's time, there will be questions following the presentation.

Ms Bunny Segal: My name is Bunny Segal and I'm chairman of the board of directors of SPRINT. That's the acronym for Senior People's Resources in North Toronto. I'm here with several members of our board: Charlotte Maher, who in her professional life is a social worker; Barb Coupal, who is chairman of our long-term care committee of the board; and Freda Finley, the past president of the board. I'm also here with two of our staff members: Bau St-Cyr, our manager of home support, and Jane Moore, our executive director.

The comments we offer to you represent the perspective of the members of our board, our volunteers and our staff, and we feel confident that they also represent the perspectives of the people who donate to our agency and of the clients whom we serve.

We decided to meet with this committee for a number of reasons. First, we're here this evening to let you know that we agree with the underlying intent of the legislation and that we applaud this government's efforts to bring to fruition a direction that has been worked on in several iterations by several administrations.

We support the effort that is being made to help people remain out of institutional care as long as they are able and as long as they wish to, and to help them maintain a meaningful and comfortable quality of life for the time that they are in the community. Indeed, this is the reason that SPRINT was originally established: to provide seniors with the resources that will allow them to continue to be meaningful members of the community.

We also believe this legislation is attempting to enable people to get to the services they need with relative ease and with minimal delay. It recognizes that people in need of service often do not have the energy to seek out the services they do need from a variety of sources. It also seems to recognize—at least we hope it recognizes—that people have a combination of health and social service needs and that this should be mirrored in the practical integration of health and social services under a single umbrella of care.

Second, we are here because we believe we have an obligation to our volunteers, to our members, to our donors and to our supporters, as well as to our staff, to ensure that their investment in SPRINT is secure, that their efforts in creating and building this agency are indeed secure and that the quality of service people have received in the community and to which they have become accustomed will continue and will grow, and that a change in structure will not undermine in any way the community-based nature of the service and the sense of ownership the residents of North Toronto feel for the agency.

From the start, SPRINT has provided a wide range of support services to help elderly and disabled persons continue to live and be active members of the community. We have provided a comprehensive case management service, complemented by volunteer services of friendly visiting, transportation and escort and telephone security, as well as Meals on Wheels.

Our respite care program was the first in Ontario and based firmly on the belief that in order for people to be maintained at home, care givers need help too. In 1987 the Alzheimer respite care was expanded and care giver education and support groups developed. In 1988 we began homemaking, home help and diners' club services, and most recently, in 1990, we launched an adult day program.

Our excellent staff and more than 250 volunteers help approximately 2,000 people each year. These clients are often people living alone with multiple health problems and limited family and neighbourhood support. Almost 40% are over 85 years old and more than half have an annual income of a lot less than \$15,000. They are served by our excellent staff corps and dedicated volunteers who gave close to 16,000 hours of service this year alone, and they represent a resource we want to see incorporated into any new system.

SPRINT has actually always provided one-stop access to service for our clients, and a wide range of services it is. But we recognize that things can always improve and, in that regard, we have formed a coalition with other organizations to broaden even further the services we provide. We see this as a positive step in the direction of a north Toronto MSA and, along with our participation on the north Toronto MSA steering committee, we look to contributing to bring long-term care reform to north Toronto.

The legislation before us today is a giant step in that direction. However, we want to share with you ways in which we believe it can be further improved so that it will actually meet its intent and ultimately serve the best interests of our community members.

Let me turn now to Barb Coupal, the chair of our board's long-term care committee. She can share with you our more specific recommendations.

Ms Barb Coupal: While it is clearly the government's and the minister's purpose to integrate community-based health and social services, we are concerned that the legislation does not in any way address or spell this out. We recommend that part I of the act, the purposes, be strengthened to ensure the reform in fact

does integrate health and social services. As a neighbourhood community social service agency, we are most concerned that after the reform the system does not continue to be driven by the health care sector as that simply maintains the status quo.

The legislation appears to give the minister unilateral power, for example, in altering geographic areas for MSAs. It is clear from the process to date that the government and the minister intend to use community consultation and due process. We recommend the legislation clearly reflect the government's intent and clearly state that the norm does require due process and community consultation prior to the minister's decisions.

The legislation refers to approved agencies. It appears that there will be interim, as well as ongoing, approved agencies. We suggest it is confusing to provide for both interim and ongoing approved agencies in one piece of legislation. We recommend that the reference to interim approved agencies be removed from the legislation and dealt with in a separate document or in the regulations. This is also important because enshrining interim approved agencies in the legislation could inadvertently serve as a block to the real integration of health and social services.

Again, we are fully confident that it is the government's and the minister's full intent to provide for a consumer-focused service. We, however, have concern that the legislation does not in fact encourage client-centred service. We note that in section 20 the agency decides the service plan while the client has only an opportunity to participate.

By contrast, at SPRINT our philosophy is that the citizens have a right to participate in the shaping of the service plan. In our assessment we work with the client and the family to determine, in the first place, what is wanted rather than what is needed. Our belief is that needs are defined by others while wants are defined by the consumer. To be truly client-focused requires a focus on client wants and, having determined what is wanted, then participating with the client to determine what service plan can realistically be put together. The client remains in the driver's seat throughout the process.

Also, in regard to consumer focus, we are concerned with the bill of rights, that it puts too great an onus on the client to make a complaint while it does not sufficiently specify the obligations of the agency. Further, we are concerned that the legislation makes no reference to the right of access by citizens. From a client perspective, there is nothing in the legislation to indicate that indeed a community service will be available when required.

We recommend a revision to the bill of rights and to section 20 to strengthen the client-centred focus of the legislation and to ensure the right of access to the service.

We just very briefly want to raise a question around the expected decrease in fee revenues. Our question is, with a significant decrease in fee revenue, how will the government plan to make up the shortfall without the risk of service reduction?

We are concerned that the list of community support services in part II, section 4, omits two services critical

to helping citizens remain in the community. These two services are currently provided by SPRINT and currently funded by the long-term care division as community support services. We do not understand why they have been omitted. We refer to our respite care service and our client intervention and assistance program. Our staff will elaborate on the value of these services.

Mr Bau St-Cyr: As the agency that pioneered in-home respite care for the elderly in 1986, we're very concerned that the role of respite care is unclear in the legislation. Although respite is included in the definition of "care giver support services" in subsection 2(1), it is not defined or listed as a separate community support service in subsection 2(4). We feel that in-home respite care, as currently funded by the long-term care division, needs to be listed as a distinct program area alongside other important services, such as Meals on Wheels, transportation services and adult day programs.

In-home respite care is a program, as you probably know, which has a very wide scope and can provide quick and flexible assistance to care giving families. It is a service which complements other care giver support services, such as adult day programs, support groups, counselling and assistance and other supports listed in the legislation. It is also a program which offers benefits and services to families that are not available in any of the other care giving support programs.

These benefits include the flexibility of one-to-one care plans; extended relief through night, weekend and overnight respite service; the provision of care regardless of medical condition; the fact that the service recipient does not have to leave the home environment in order to receive service; and the fact that there's no need to engage in group activities if the service recipient is either unable or unwilling. Essentially we're sending someone into their home, in their environment.

The program, and this is a crucial point, is also available to care giving families who simply need relief from the care giving burden and companionship for the service recipient without having the need for either personal support or homemaking. It is a program that simply exists for providing care giver relief and support so that the person providing care can in fact continue to do so.

It is of course unreasonable to expect one care giver to provide three consecutive eight-hour shifts of care giving on an ongoing basis, day after day after day, without resorting eventually, after burnout, to institutionalization. If we are in fact going to try to keep people in the community, we feel at SPRINT that we definitely need to look at respite care and define it in a much clearer way in the legislation.

We have a case study we want to share with you very quickly. Mr and Mrs G presently use SPRINT's in-home respite care service. They live together in an apartment in north Toronto and have two children, both of whom live outside the city. This leaves Mrs G as the sole care giver to her husband, who has short- and long-term memory loss. Mr G also has physical problems. He has angina and problems with mobility. He's exceedingly anxious in groups, which makes him unsuitable for our adult day

program. He's very suspicious and prone to wandering and cannot be left alone. Coupled with all of this, Mrs G's health has begun to deteriorate. Prior to accessing the respite care service, Mr G, an intelligent man, spent most of his waking hours in front of the television set being entertained by television or in fact staring at the doorway. Mrs G felt, and was in fact, completely imprisoned by the situation.

The provision of 15 hours of respite care service weekly to this couple has accomplished a number of objectives: relief for Mrs G; flexible respite scheduled to meet her needs; minimal anxiety for her due to the one-to-one contact in a familiar surrounding, thus minimizing the risk of angina attack; help with personal care and housekeeping; importantly as well, care for the service recipient: cognitive stimulation for Mr G, outings to the ROM, to the zoo, to Harbourfront, walks in the park, lunch in restaurants and the companionship of a brand-new male friend coming into his home and having a very important relationship with him; also, of course, the delay or possibly the avoidance of institutionalization.

It is our feeling that if this reform truly seeks to provide supports to enable families like the Gs to maintain themselves in the community, we must ensure the creation of a continuum of services able to assist care givers in all situations. In-home respite care is a key part of this continuum and needs to be recognized and funded as such.

1920

Ms Jane Moore: The other service that is not listed in the legislation, as mentioned by Barb, is client intervention and assistance.

With this funding, because currently it is a funded program, SPRINT provides intensive case management to citizens with complex needs and who are at high risk of institutionalization because of a combination of factors, such as physical frailty, mental confusion and minimal supports from family and friends.

We estimate that this intensive case management service is needed perhaps by only 5% of the seniors' population. But for that number, the client intervention and assistance service is often the critical factor between remaining in the community or being institutionalized.

Client intervention case management staff assess strengths and deficits with the client in the areas of mental health, physical health, their activities of daily living, social networks and economic resources. On that basis the staff and the client agree upon a plan of action which tends to be very complex, being complex cases, and involve a very wide range of players.

Our client intervention and assistance case management workers are highly skilled in community-based geriatric work. They have assessment skills; they are familiar with community resources; they have the advocacy skills to deal with bureaucracy, cut red tape and bring about needed services; they understand psychosocial needs; they have the counselling skills needed to work with complex family dynamics; and they understand the importance of and are skilled at strengthening social networks.

The SPRINT client intervention and assistance case

management staff act as travel companions, as we say, "walking with" the client as needed and serving the client over the long haul.

Crisis intervention obviously is part of this service.

The program provides the least intrusive service possible, views clients and their families holistically, aims to uncover and build on inherent strengths which we believe are present in even the most complex and difficult cases.

Just a quick case example: Miss K, a 95-year-old single woman, has lived with a friend for 40 years. The friend was hospitalized with a broken hip. Miss K was referred to SPRINT by the super in her apartment building. A good neighbour had been involved, but became quite helpless with the situation and wanted to withdraw. The immediate concerns were meals and twice-daily eye drops. Over the next two weeks, it developed that the friend was not going to be coming home.

The SPRINT intervention worker visited with Miss K to determine what was wanted, took her to visit her friend in the hospital and discussed with the two of them what steps might be taken. Our worker initiated joint planning with the hospital staff for both the women, did advocacy work to ensure ongoing nursing visits re the eye drops, coordinated evening homemaking services and did counselling to help the neighbours continue to be supportive.

SPRINT volunteers were recruited to do daily security checks. Another was recruited to do friendly visiting, crucial to helping Miss K remain rooted in reality and prevent her world from shrinking even further. With the intense involvement of our worker, the situation stabilized. Miss K is able to function in her apartment, knowing that her SPRINT worker is available at the other end of the telephone as needed, as well as being supported by the volunteer driver who takes her to the hospital to visit her friend, the security check and friendly visitor, as I mentioned. As well, her neighbours, with our worker's help, now feel that they can pick up again and continue to support Miss K. We hope and in fact expect Miss K will soon feel up to trying our diners' club or our peer support group to develop some new friendships.

We do not doubt that but for our client intervention and assistance program, Miss K would have remained extremely distressed, upset, unable to cope, her neighbours would have withdrawn support and she would have quickly been institutionalized.

We also point out that the client intervention and assistance case management service as provided by SPRINT is also provided by other home support agencies across Metro and that it is entirely unique. Neither hospital discharge workers nor hospital social workers nor home care coordinators have the mandate to provide the intense, ongoing case management as described. The loss of this program will ensure an even greater number of people requiring institutionalization. Thus, we strongly recommend that the current client intervention and assistance case management service be included in the legislation as a community support service.

Ms Segal: To just summarize, what we want to avoid

is a bureaucracy where people are vulnerable by their dependence on a single source of help. What we want to avoid is a bureaucracy that has no allegiance to the community and that achieves efficiency at the expense of flexibility. What we want to avoid is a system totally funded by and accountable to the government, not the people it aims to serve. What we want to avoid is a pseudo-integrated system, essentially operated and controlled by the health sector, in which health care needs are paramount and quality of life is defined by the ability of the body to function.

What we want to ensure is an integrated system where people are treated as a whole, where health and social services draw no lines and where the client, as the consumer and actually the person who does pay for this whole service system, calls the shots on his or her own behalf.

Mr Jim Wilson: Thank you very much for your presentation and the annual report. Some of the statistics contained in it are quite impressive in the numbers of people you serve. Indeed, in the supplement to your oral presentation, there's a bit of a description of a couple of the programs you mentioned, such as client intervention and assistance case management and the in-home respite care program, and I note also that you had an emergency quick-response respite care program, which by the sound of it was quite successful.

I wanted to ask you really just one thing, and that is with respect to the multiservice agencies. I assume discussions are ongoing in your area now, if you could give us a feel for how things are going and where you think they're directed in your specific area with respect to who will end up being the MSA and what it will look like. We're quite in the dark with respect to what MSAs are going to look like and how they're actually going to function. Some people are coming to this committee for answers. I can tell you that the committee is looking to a number of the groups for answers because the legislation isn't terribly specific in areas of giving us a good overview of what the MSAs will actually look like, who will be on them and how they will operate, so perhaps you want to tell us that.

Secondly, I have a question, which was the group's question about the decrease in fees. Perhaps the parliamentary assistant will want to address that. I don't see how there'll be decreases in fees, and maybe you can explain that to me, since you made the comment and asked the question.

Ms Moore: In the North Toronto community, we have an organization called People and Organizations in North Toronto. It has spearheaded the community consultation process that we believe will lead eventually to a North Toronto multiservice agency. Many North Toronto players are participating in this development, including a wide range of consumers, a local hospital etc.

Mr Jim Wilson: And how's it going?

Ms Moore: There are difficulties on the road towards the local MSA, without a doubt. There's the health sector and there's the social service sector and it's going to be difficult to have the true integration and not have the domination. From our perspective, we are considerably

worried about the domination by the health care sector.

Mr Jim Wilson: I had a second question, which was the decrease in fees. Could someone just please explain that?

Ms Coupal: As things stand presently, approximately 25% of our budget comes in the form of user fees, so our concern is that, as we understand it, we're going to have an envelope of money with which to serve our clientele in a new MSA, and we have concerns about that lack of contribution by the individual and how the shortfall will be made up.

1930

Mr Jim Wilson: The whole long-term care reform actually includes a huge increase in user fees, and they are permissible under this act. Maybe the parliamentary assistant would like to clarify.

Mr Wessinger: I don't know whether I can clarify because we'd have to know what you presently charge fees for and to see if there's any aspect of the prohibitions. In order to answer the question, we'd have to have a list of the fees charged and that would have to be reviewed by the ministry. But perhaps I can have a policy person indicate generally what the situation is with respect to fees.

Mr Quirt: The bill allows for fees to continue for a number of community support services that normally have had fees associated with them; for example, fees for meals delivered to people's homes, fees for volunteer rides to the doctor or shopping, fees for home help when a student might come and rake the leaves or clean the basement of an elderly person's home.

There are two changes with respect to fees in the community service sector brought about by the long-term care reform. One of them relates to the way in which user fees would be arrived at. We have a program design work group advising us now on how best to establish some more consistency in user fees for those programs I've mentioned. I suspect what will happen is that they'll recommend to us some principles about user fees. For example, they may recommend that when it comes to meal programs, the client should pay the cost of the actual food or whatever, or establish those types of guidelines that agencies can use across the province. I doubt very much whether they'll recommend to us that one flat, standard fee be applied in all circumstances everywhere.

The second change with respect to user fees relates to day programs. Consistent with our approach in long-term care facilities, we don't want our consumers paying for their care or services or programs, so we will be offering day care programs without a user fee. User fees for day care programs now vary from program to program. Some are free now, some aren't, and the percentage of revenue generated from day programs is a relatively small percentage when compared to the revenue generated from meal programs and transportation. Clearly, MSAs and home support agencies will have their budgets adjusted to reflect that. Currently, some of our programs are losing revenue from the home care purchase of meals, and in those situations we are adjusting the budgets of agencies

to make sure that shortfall in revenue is made up by provincial subsidy.

Mr Jim Wilson: Perhaps I can just add that if we look at 1993-94, the statement of revenue and expenses from SPRINT, there's a considerable amount of money brought in under the adult day program. The expense recovery line item is \$293,628. Is that perhaps what you're referring to?

Ms Moore: No. If I could clarify that, we have a contract arrangement with a local community health centre. That's a transfer, so that does not reflect entirely fees. We do receive significant fees for services that would qualify as personal support services. People currently receiving SPRINT homemaking services and paying for those services, as we understand it, under the new legislation would no longer be paying for those services. So we do expect a very significant decrease in our fee income.

Mr O'Connor: I appreciate you coming forward. We've heard a number of concerns being raised, and no doubt we will as we hear from people who are out there providing what they feel and what are in fact good services today.

A caution that is quite often placed before us as legislators is that when you try to define as much as you possibly can in legislation, you end up excluding stuff. I think there's usually a caution put in place so that when there are a number of areas you'd like to see put into the legislation, there's a reason for not everything being spelled out as clearly as you possibly could in the legislation, because that creates exclusions, and that's not the intention. The intention is to provide for the needs, for the services that the consumers require out there, and some of those services will evolve. You talk about the respite care program that you offer, and 10 years ago—how long ago was it?

Ms Moore: It was 1986.

Mr O'Connor: Less than 10 years ago; it didn't exist. So if we were 10 years ago doing this, something like that could have been excluded, and who knows what else. I hate to see things defined too narrowly, because then you create exclusions.

One of the things we have heard over and over again and will probably be a recurring theme is that the development of the MSAs is going to cause the loss of volunteers, that they're not going to be able to provide the same basket of services that is being provided today because you could be excluding groups out there that are providing services. We've heard from groups like the Saint Elizabeth Visiting Nurses that, "You're going to exclude us and that service isn't going to be provided, and it's a needed service."

What you could offer us is maybe some advice on how we can make sure the MSAs, as they evolve and develop, are not a bureaucratic nightmare, the bogeyman, something terrible, because I think what you've demonstrated in the short period of time that you've been around is that you can bring in a lot of community services under one roof and provide a very comprehensive set of services. The key here is going to be focusing on what the needs

of the consumer are and making sure those needs are met. So if you could offer us some advice as to how we might be able to share that, I'd appreciate that.

Ms Freda Finley: One of our major concerns is the retention of not only volunteers but volunteer dollars. We feel that we have a very strong commitment from our volunteers at this point because they have an input into the programs we provide: They sit on our committees; we have a very active board. Our concern is that if the MSAs are set up in a way that does not maintain that accountability to the community, there is a serious risk of losing both the volunteers and the dollars.

Having said that, we have very committed volunteers whose major commitment is to the client, and they will continue, but the dollars and the commitment from the community to be involved in the policy, in the delivery of those services, I think is seriously at risk if it is perceived to be a bureaucracy.

Mr O'Connor: The local planning I think is going to be essential here for the retention of the volunteers and for the network. Local planning is going to be a key to the development.

Ms Finley: I guess my concern is that I don't see that addressed in the legislation.

Mr O'Connor: Do you have any suggestions?

Ms Finley: I'd be happy to give them to you, but I don't think you've got enough time tonight. The issue of governance isn't really addressed in the legislation. It was discussed at great length in the deliberations beforehand, and it was a great disappointment to us to not see it there.

Mr O'Connor: Because they need to evolve locally, and if we were to put down something—like I said, once you start establishing everything in legislation, then you're excluding too much, and for it to evolve locally, it does need that development to take place.

1940

Mr Jim Wilson: But you're going to do it through regulation and there's no public input in regulations.

Ms Finley: That's right. I mean, if it's going into regulations—

Mr O'Connor: It's not going to be. It's not going to be completely that way.

Ms Charlotte Maher: Yes, but you've got to have some guidelines to that. One of my major concerns in this legislation is that the interim period and the long-term period are not divided up. They seem to be merged in the legislation. That was mentioned by Barbara. But what that does is confuse the issue. The interim period must aim towards the end period, in my view. The interim period can be four years or five years or two years or however many years, and during that period it seems to me there need to be some guidelines to the communities in order to have—but we've got books and books and books. Many, many volumes have come out on this thing. It's not foggy—at least, some of the details are foggy, but the thrust is not foggy, I do not believe, and I believe the thrust as it has been described by the minister is quite consistent with the thrust that was very neatly expressed, I thought, here today in terms of where the power is and who's in charge.

Mrs Sullivan: Dianne Poole, who's a member of our caucus, has described your agency frequently in our caucus discussions of long-term care reform and is very much your advocate, I will tell you, around this place. I'm interested in some of the comments you've made with respect to funding issues. You're the first organization that's brought in its balance sheet so that we can actually address the actualities of revenues and so on. I note from yours that your non-government funding amounts to about \$231 million vis-à-vis—

Ms Moore: No, thousand.

Mrs Sullivan: Sorry, thousand. Wouldn't it be great if it were million? It's \$231,000—

Mr Jim Wilson: That's including Barbara's personal contribution.

Mrs Sullivan: —versus Comsoc funding of \$781,000. That's a very high proportion of your total revenues. Questions other than the volunteer donations and the fund-raising which are recorded in your statements relate to whether in fact the MSAs would continue to be eligible, by example, or qualify for the kinds of municipal funding that you're receiving. Ontario Trillium Foundation funding and I think United Way have already expressed considerable reservations about funding MSAs. Certainly, they have in my community and I understand the same is the case in Toronto.

I think the funding issues won't go away and they're going to have to be resolved. Either the government has to agree that the service levels that are going to be required will be funded by the province or we have to understand that the promises that are being made to people with respect to the way this act will unfold as it's implemented are in fact not going to be kept.

I've got a couple of questions to ministry officials, first with respect to in-home respite care, wondering if those services are included under community support services, item 3, care giver support services, for which charges can be made or fees are allowed.

The second is the client intervention and assistance, the case management that you spoke about. Is that included under the social work services as professional services for which no fees are allowed? We've got to know what the government means by the words that are there. They may be included or they may not be included, but we should understand what's there.

Mr Wessenger: I will ask legal counsel to respond to that.

Ms Czukar: With respect to your first question on respite care being part of care giver support, the answer is yes, it's included in the definition of "care giver support services," it's a community support service. Subsection 25(2) says that if an approved agency provides a community support service in accordance with the plan of service, it can't charge for it except in accordance with the regulations. So if regulations are made that would allow an agency to charge fees within a range of fees for that kind of service, then they could charge; otherwise they couldn't.

I'm not sure I caught all of your second question, if you could just repeat that one.

Mrs Sullivan: The client intervention and assistance, which is the case management approach that's been adopted by SPRINT—

Ms Czukar: Right, okay.

Mrs Sullivan: —largely, I think, under the leadership of social workers who coordinate the teams and whether that service would be included as a professional service under subsection 7(2), social work services.

Ms Czukar: Case management is really defined in section 20, which is the development of the plan of service assessing requirements with the participation of the family and the person, determining what services the person's eligible for, what the plan of service should look like, and then section 21 is saying that the services should be provided. That is really the description of the kind of case management service.

The reason case management service isn't articulated as a specific service in the four categories is because we had to come up with a description of what was included, because there are so many descriptions of what a case management service is. This was the way that we ended up with it: as an obligation on every approved agency to assess requirements with the person's participation and so on.

So that's where it is and it could be done by teams or by a case management worker. I guess MSAs could work out different staffing structures for how they wanted to best accomplish it.

Mrs Sullivan: My last question relates to the kinds of integration that you've attempted with the community services that your organization offers and health services which are offered by other agencies. I noticed that at one point you did a pilot with the VON. Can you tell us where that ended, or has it ended?

Ms Moore: No.

Mrs Sullivan: All right, so it's still ongoing. Then, in the next case, would you contemplate applying or pressuring to become an MSA?

Ms Moore: Sorry, what was the last part?

Mrs Sullivan: Would you contemplate applying or pressuring or whatever the process is to actually be named as the MSA for north Toronto?

Ms Moore: We had understood that no agency was to be an MSA, so we have gone on that assumption. Could we have comment—

Mrs Sullivan: Could the ministry confirm that that's the case? This is highly problematic, particularly—I say particularly in communities outside of Toronto, but that may not be the case; that might just be my prejudice because I'm from outside of Toronto. But let's have a clear statement of whether an agency can be an MSA or not.

Mr Wessenger: Certainly it's my impression it can, but I will ask policy to—

Mr Quirt: Very clearly, we do expect that many of our existing agencies will become multiservice agencies. There's absolutely no provincial direction to suggest that some of our existing home support or other health provider agencies can't become an MSA. That would be

quite a foolish statement for us to make.

As a matter of fact, what we're hoping is that consensus will be reached through the DHC long-term care planning process about which agency is best equipped to become the MSA, whether it's two agencies or three that join together, whether it's one existing agency that expands its mandate. In some places, it may well be that the community planning process says, "Well, heck, let's start a new agency, because that's what the consensus is around the table here." I suspect that it would be in the minority of cases that an existing agency or group of agencies wouldn't form the nucleus of the MSA.

So clearly we're not saying it has to be a new agency. In the discussions around the Metro Toronto situation, with over 100 agencies in Metro Toronto and a DHC recommendation for between 15 and 20 MSAs, there may well be some other perspectives from the point of view of the long-term care planners in Metro about which I'm not aware. But there's certainly no provincial direction that an existing agency can't be an MSA.

Mrs Sullivan: If the province, though, concurs that an existing agency, as a policy matter, can/should become an MSA, what control over the DHCs is the province going to take? Is the province going to say, "If you rule out an existing agency, DHC, we're not going to accept that, if there's an appropriate agency," and, "Please look for an appropriate agency"? Is the province going to just leave it all out to this vast unelected body to do these things?

Mr Quirt: No; the province is looking for advice from district health councils and from long-term care subcommittees. The province has specified the composition of those long-term care subcommittees so that perspectives of consumers, perspectives of social service providers and perspectives of health care providers are reflected in those discussions.

We have confidence that the district health council process, given its representativeness and given its direction to ensure that social and health perspectives are fully considered, will give us good recommendations on what their community feels is appropriate.

1950

Obviously, it is advice that the minister gets, and in the off chance that it's bad advice she gets, she may well choose to decide alternatively, but we're certainly not starting out on the premise that the community planning process is going to provide bad advice. We expect that nine times out of 10 it's going to be solid advice based on a consensus arrived at at the community level. That's a much better alternative than simply directing from Queen's Park which agencies or organizations should become MSAs.

The Vice-Chair: Ms Sullivan, had you completed your remarks?

Mrs Sullivan: I think that the presenters have a response.

The Vice-Chair: Yes, please, go ahead.

Ms Maher: This is absolutely counter to everything I've heard so far. One, and I quote—I'm not going to quote, but I'll give you the gist of where I got this idea. The so-called salmon document clearly is quite different

in terms of that. I'm talking about Metro, but I remember hearing the minister at the initial Metro conference, where we began the business of long-term planning, when she was absolutely clear when asked if this were to be the case. I've subsequently heard—what was her name?—Karen Goldenberg indicate there will be a transition period during which time one of the agencies may assume these responsibilities, but this is not the intent in the long run. I'm astounded to hear you speak that way.

I don't think that it's just Metro. I think this is more broad than that. This is the kind of thing I think is dangerous and serious in terms of the community planning process. You can't just shift gears midstream. No one's going to believe you or care. It's a very serious matter. I believe the community planning process can work but it can only work with some consistency in direction, if the guidelines are consistent. I'm astounded.

Mr Quirt: The point I was trying to make is that the province has not directed the community planning process and DHCs, that under no circumstances can you recommend an existing agency become a multiservice agency. We have not done that.

In the discussions in Metro Toronto, given the complexity, it may well be—I don't know, but it may well be—that the MSA subcommittee and the deliberations of the DHC in Metro are leaning towards the establishment of new agencies. It's not a provincial policy that they be new agencies. It is a provincial policy that the local DHC-led planning process make recommendations to the minister on which agencies become MSAs or how MSAs are formed. To that end, in Metro Toronto, I understand that there are, in about 15 communities, a number of agencies that have formed planning consortia that are sorting out among themselves how best to establish a multiservice agency in each of those geographic areas. We're prepared to support that process by providing facilitators or providing a grant to each of them of between \$5,000 and \$25,000 to let them develop their MSA proposal.

It is not our position at this time that we preclude an existing agency from being recommended as a multiservice agency. Once that's recommended, then obviously that agency would have to meet the expectations of the province in terms of board composition and other expectations, and it's conceivable an existing agency would have to reconfigure its board to make sure that consumers were adequately represented, for example. But there's not a provincial direction to preclude an existing agency from becoming an MSA.

Ms Moore: I guess I would suggest that this information be made public, particularly in Metro where organizations like SPRINT are really turning themselves inside out trying to figure out how we in effect dissolve, which is what we understand we have to do, and resurrect in this new MSA form.

As it happens, in north Toronto SPRINT is really in terms of home support, so it's not as if there's this plethora of agencies that have to be amalgamated. There's SPRINT and there are two very tiny, one-service agencies, SAINTS and Yorkminster. The three of us have an integrated client database; we work together very well.

What we need at this point is to integrate with the Metro home care program. If we accomplish that, we will have accomplished a north Toronto MSA, but because our understanding is that the whole world has to be involved in doing this, we've gone back to square one and we have this really quite major community planning process in the works which includes, for example, the local hospital who is very interested in determining how this MSA is going to develop, and has become a very complex process.

Ms Segal: And if I could add to that, in the process of doing that we will spend the \$25,000 that you so generously want to give us to do exactly what you say we don't have to do.

Ms Finlay: Precisely.

Ms Maher: Something's very wrong.

Mr Quirt: Just to further clarify, the process to arrive at which agency, new or existing, should become the MSA has to be a collective process; it has to involve the various stakeholders and people like hospital representatives and representatives from home support agencies and representatives from health-care providing agencies and a consensus has to be reached.

It may take a while and it may take some money to help that consensus be arrived at, but that consensus, from the provincial policy perspective, does not have to be—we have not sent out an edict that every one of our transfer payment agencies is hereby dissolved and everywhere in Ontario there has to be a brand-new entity called the multiservice agency. We have not said that and we expect that existing boards will happen.

Mrs Sullivan: That's been said on many, many occasions.

Mr Malkowski: The issue that you had raised earlier just in regard to client intervention and case management as well as in-home respite care: Having heard your concerns regarding it not actually being in the legislation itself in terms of a mandatory service for all MSAs, if I could give you two options.

Right now there is the flexibility for MSAs to include a variety of services which would include those types of services. Do you feel satisfied with that, or do you think that it actually has to be spelled out in black and white in the act?

Ms Moore: While we did hear Larry O'Connor's suggestion that the more you spell out the more difficult it can become, nevertheless, because all the other funded services that SPRINT currently provides are spelled out but there is the omission of client intervention and respite care, we feel this is very significant and we think it is critical, given what we have described to you as to how important those services are to help people remain in the community, that they be reinstated.

Mr Wessinger: I think I'd like to have the policy adviser give some clarification on that.

Mr Quirt: I'd just like to assure the delegation that the intention of spelling out the mandatory services in the bill was not an intention to preclude or to eliminate some of the important, innovative, flexible, needed services that we now fund. The intention was to make sure that when

MSAs were established they were inclusive in terms of the services provided.

Let me assure you that the type of in-home respite service that you're providing is precisely the kind of thing we'd like to see across the province, the kind of innovative support to care givers that's needed. In addition, the client intervention service that you're providing—you could describe it as client intervention; you could describe it as intensive case management—we applaud you for that and we hope that more organizations will do it. It's precisely the kind of thing that we think is going to improve the community service system and is going to allow more people to live at home rather than accessing care in a facility.

Respite care is a difficult thing to define in a bill in that, as you know, respite care can be provided by a volunteer who visits, respite care can be provided by a homemaker who goes in and does some homemaking activities while a care giver takes a break, respite care can be provided by another professional like you employ, or it could be provided with a short stay in a long-term care facility. So respite is a bona fide, legitimate and important objective of a number of different aspects of the service system that we want to create.

The Vice-Chair: Any final comments that you'd like to make?

Mr St-Cyr: I have a comment related to respite care. Respite care has been provided for ever, because for ever we've had family members that have become ill, that have become frail and that have needed support by their family members and the community. Recently, it has been provided through programs called homemaking programs.

Respite care, to be significant, has to be provided in a large enough number of hours to allow a care giver, who is providing constant 24-hour care, to get out and really get a break. Homemaking programs, I would submit, have not been funded to provide that level of care. The type of respite care we're getting currently under the integrated homemaking program requires the need for personal care. Not all care givers need personal care. They need respite care. The type of respite care available through homemaking programs funded under home support agencies cannot begin to address the need of the families, because the funding is so limited and homemaking programs generally are offering three to six hours of homemaking a week to a family. Respite care to have an effect for some families is needed in excess of 15 hours, in excess of 20 hours. So to hide respite care in homemaking or under personal support means making it disappear in areas where it exists currently. I would really suggest caution in this area.

2000

Mr Quirt: It's certainly not our intention to hide it there. For the very reason you've pointed out, we do now fund you to deliver the kind of home support in home respite service you describe. If we thought it was a lousy idea, why would we be funding you now?

Mr St-Cyr: Yes, of course. I wasn't suggesting that you were maliciously hiding it. I was just suggesting that

we would like to see it come out a little bit more in the open because we see it as such an important part of community supports.

Mr Quirt: We agree. It's a very important part. We thought we had addressed it specifically. We described respite as a bona fide reason for delivering service even if somebody can't be defined as in need of professional health care service or in need of personal support, or whatever, the family being the client as opposed to the individual. We take your point that if you've misconstrued it, other people may as well.

The Vice-Chair: Thank you for your presentation. Pleased to hear you this evening.

Mr Jim Wilson: While we're changing groups, could I just ask for a bit of information from the parliamentary assistant. One of the points that this group raises, and particularly with the question of fees is—the way this bill is written is if you get a plan of service, if you're eligible for a plan of service, you get your services free. If, for example, respite care is included in your plan of service, there's not to be a charge for it, even though it falls, apparently, under community support services where there may be charges for some of those services if it's not part of someone's plan of care. I guess what we need to know is, how do you become eligible for a plan of care? If we look at section 20, we talk about the assessment of a person's requirement—sorry, plan of service. What the heck is the name of that?

Ms Czukar: Plan of service.

Mr Jim Wilson: Plan of service. I mean, basically if you don't get on the plan of service, you're in trouble in this system. I think where the narrowing of the system comes in is who becomes eligible. As far as I know, I haven't got any notes on eligibility and assessment, and it is rather crucial because you can't access this thing in a cost-efficient way if you don't win the jackpot.

Mr Wessenger: I'll ask counsel to respond to this. I think the section you're referring to is section 25, where you're quite right, that if—

Mr Jim Wilson: Well, 20 through to 25.

Mr Wessenger: "If an approved agency provides or arranges the provision to a person of a homemaking or community support service...the approved agency shall not require payment...except in accordance with the regulations."

Mr Jim Wilson: But it would be important for a group like this, for example, with the myriad of clients it has, in order for budgeting purposes, for example, they would need to know how many existing clients that are receiving services at cost or no cost, how many would actually be assessed to qualify for a plan of service and therefore have no cost.

Mr Wessenger: I will ask legal—

Mr Jim Wilson: It would be very, very difficult, at this point, to—

Ms Czukar: That's right, and the eligibility criteria will be in the regulations. So the eligibility criteria, just as they are for facility services, will be the guidelines that the approved agencies use to determine what kinds of services people are eligible for and what the limits of

those services are. That's what is to be in the plan of service as described in section 20.

Mr Jim Wilson: But I would have thought, though, after we went through this in Bill 101 and eligibility criteria to get yourself or a loved one into institutional care, that the government of the day would have learned something about the displeasure we expressed last time about this. Do you want us to go through that again now for the next five weeks, about having no eligibility criteria here and yet you want us to endorse legislation? We don't even know who's going to be able to access these services.

Mrs Sullivan: Or what level of services or at what—

Mr Wessenger: We can ask policy. Maybe he can provide more clarification on the—

Interjections.

The Vice-Chair: Please.

Mr Jim Wilson: I thought we made it clear a year ago or two years ago we did not want—

The Vice-Chair: Please. We will not have cross-conversations, and we'll have one speaker at a time from now on. Would you care to respond, Parliamentary Assistant?

Mr Wessenger: I think Mr Quirt would like to respond to the eligibility question.

Mr Quirt: We'd be happy to provide to the committee a presentation on the eligibility criteria. As members of the committee would know, the eligibility criteria for any community service are nowhere to be found in any legislation currently. We have eligibility criteria in place now, and representatives before the committee are familiar with some people not being eligible for home care services or, in fact, some people not being eligible for some of the services that SPRINT provides with funding for home support services.

Those services that are necessary in order to maintain someone's lifestyle independent in the community, those services necessary to allow people to remain at home as opposed to moving to a facility, are those services that will be included in the plan of service and not charged for.

If you, Mr Wilson, were to ask SPRINT for a homemaker, they would determine a reasonable fee and charge you that. In that case, they'd determine that you didn't need that service to maintain your independence in the community. All of our community service agencies across the province are familiar with some clients who aren't deemed to be in need of the service being charged a fee, and others not, in that the Red Cross and the VON and many providers are in the business of both providing publicly funded and supported services for clients of the system and also offering services to other people who don't meet the eligibility criteria of government-supported programs.

Mr Jim Wilson: I understand that and I appreciate that. So what you're telling me is that the eligibility criteria—

Mr Malkowski: On a point of order, Mr Chair: I know that we have a very long list of speakers and we

are over an hour on just the first presenter. I wonder if we can move on.

The Vice-Chair: Yes, that's correct. We are slightly over an hour, in which case—

Mr Jim Wilson: I'd like to take Mr Quirt up on the offer, if we could set aside 15 minutes to go over eligibility criteria that currently exist and what it's going to look like in the passage of this bill.

The Vice-Chair: Thank you. That's very—

Mr Quirt: I'd like to suggest to the committee that we have an outstanding presentation on the technical aspects of the bill which we could incorporate in perhaps a half-hour presentation, and we'll be able to cover off the determination of eligibility at that time for you as well. We're getting a lot of advice currently from our program design groups on that topic.

Mr Jim Wilson: Let's do that.

The Vice-Chair: Thank you. That would be very helpful. That will be later tonight perhaps, or some other date.

Interjection: Not later tonight, no.

The Vice-Chair: Well, I've got a one-day stint at this, you see.

Mr Jim Wilson: I hope you won't mind sitting through the presentation and telling us what it was like.

The Vice-Chair: Thank you for your presentation. You can see there's very keen interest in your presentation and your remarks.

Ms Segal: Thank you for your time.

2010

COMMUNITY HOSPICE ASSOCIATION OF ONTARIO

The Vice-Chair: The next presentation will be made by representatives of the Community Hospice Association. Welcome to the committee. Please introduce yourself when you're ready and proceed with your presentation. Hopefully there will be time for questions following your presentation.

Ms Heather Balfour: First of all, I'm very pleased to be able to be here this evening to present to the committee. We certainly appreciate this opportunity. Marilyn Davidson, the chair of our public policy committee, is unable to be with us tonight, so it will be myself who is doing the presentation.

I am Heather Balfour and I'm the executive director of the Community Hospice Association of Ontario. I have brought with me tonight a written presentation which I'm not going to belabour. I know we're not having a lot of time this evening to talk about a lot of things, so what I would like to do, briefly, is three things tonight.

I would like to talk to the committee briefly about hospice and what hospice is in Ontario, because we do find that we're not a very well known commodity. Then I would like to talk about some of the concerns that we have in the hospice field with the act, and with some of the happenings we see in redirections in long-term care and in the development of MSAs in terms of hospice care. I'd like to end on a more positive note in terms of some recommendations that we have as to how the process can be easier for everyone who's involved.

First of all, I'd like to talk about hospice. I am an employee of the Community Hospice Association of Ontario. We're a fairly new organization, we've only been around for five years. We were established in 1989. At that time we had eight hospice programs in the province. We've now expanded to over 60 hospice programs. I think that's a telling factor in what's happening with people with terminal illness in the province. We are seeing a dramatic increase year by year in the number of hospice organizations being developed, as well as the number of clients and families that are being cared for by each hospice program and the number of volunteers who are becoming involved in caring for people in the hospice field.

In terms of what it is actually that a hospice does, hospice cares for people with a terminal illness and their families. The intent of most of our hospice programs is to care for people in their own homes, although of the 60 programs we have now, we do have one that has a freestanding building which, of course, is Casey House in downtown Toronto.

The philosophy of hospice includes the fact that the client is a director of the type of care that they're getting and the service providers who are coming to them in their own homes. So in very many ways the hospice philosophy mirrors a lot of what is in this act in terms of choice, client and consumer choice, and the type of services they're getting, and the idea that people like to receive services in their own homes wherever possible, as opposed to institutional care.

Hospice care is provided primarily by volunteers, which is certainly a plus, I think, to the entire health care and long-term care system.

Most of our hospice programs provide care to people regardless of diagnosis, although some of them are for people living with cancer specifically and Casey House, of course, is specifically for people living with AIDS.

The concerns I would like to talk to you about tonight are basically some concerns that we have had in the hospice field in response to some of the things we have seen coming out in redirections in long-term care and some of the discussion and information that has come out in terms of the development of multiservice agencies.

I think one of our major concerns right from the beginning is the fact that hospice and palliative care is sort of on the fringes; it's not really mentioned in the act. However, we're getting mixed messages in terms of how hospice is going to be provided in long-term care. We get some messages that say, "Oh yes, you will be a part of the MSA." Sometimes we hear: "Oh no, you're not a part of the MSA. You will be a satellite program that will be offering care as a distinct separate part from an MSA." So there's some confusion about how really do we fit into the system, and I think a lot of that is because of our timing.

We at the provincial organization receive no government funding at all. We pay for our services through donations and some very small hospice member fees that our agencies pay towards us. Our hospice programs have recently started to receive some government funding. It's a small percentage of their budget and I think one of the

challenges we've seen is the fact that that's really just started in this last year. March and April 1994 were the first months that we were starting to see some of the funding flow through from the government's palliative care initiative, which was announced in December 1992.

In a way, that's been wonderful for us in terms of having some support for some of the services that we're offering, but at the same time it's been a real challenge because nobody knows quite where we fit: Do we really fit with the redirections in long-term care? Because we've not been there before. We've had some struggles in trying to follow the information that comes out.

Just to give you an example, in some of the information it says, "You will, of course, still be expected to raise the 30% money from the community that you raise now." Well, of course with hospices the 30-70 split means nothing. Many of them still raise all of their own money themselves, and for those that do get government funding it certainly isn't a 30-70 split. So in many ways we're having real difficulty trying to work our way through the system and keep up with what's coming out to us in terms of changes in MSAs and redirections in long-term care.

We have a concern about volunteers. As I listened to the presentation previous to me this evening, I think there are a couple of areas where we probably share some concerns. As I mentioned earlier, hospice is almost primarily care provided by volunteers. Most of our hospice programs, if they have any staff at all, may have one less-than-full-time staff person whose role is to coordinate the services, to recruit and orient volunteers, to train them, to supervise and then to coordinate their care with the other care providers who are from our partners, from the medical and nursing community, homemaking agencies, who will also be providing care to people in their own homes. So there's a question as to what will happen with those volunteers.

There's a lot of fear about: "What does the MSA mean for my volunteer program, my hospice that is primarily volunteers? Are they still going to come and work from my hospice when it's no longer there if in fact it's going to be a part of an MSA structure?"

Fund-raising obviously is very much a concern for us when that's primarily how we pay for our services. We've tried to ask questions as we go along in terms of what does it mean for us. If we're a part of an MSA that no longer has a board of directors who will raise the funds to run the hospice program, because of course at this point the board plays a very major fund-raising role in terms of raising the funds to keep the hospice organization going—that's been very difficult, again, in reading the information that's coming out, trying to figure out where the funding for our hospice programs will come from.

A fourth concern that we have, which I think can be demonstrated as a real one, is the lack of knowledge about hospice care. Obviously, that's partly because we are such a new organization and a new field of service in Ontario; also because we simply haven't had the time or the resources to do the public awareness that we need to do. When you're trying to raise funds to provide the

service that you provide, it's very difficult to also be trying to do a lot of public awareness at the same time.

We have concerns about that for a couple of reasons. If we are going to be a part of redirections in long-term care in the MSA structure, will decisions be made on how hospice fits into that, with full knowledge of what it is that hospice does, and what hospice services are and how they fit into the other care providers in the community? We have some concern that if decisions are made without full knowledge of how hospice works, is it really going to be made in the best interests of the clients we're serving at this point?

Another concern we have is simply to do with research about the benefit, both human and cost benefit of course, of hospice care. We certainly have not had the time or the resources to do a lot of research into the kinds of care that we're providing in terms of the benefit costwise and also the benefit humanwise.

We believe that people prefer to be at home and that we're providing good care, but we've not had the resources to determine, is that in fact a more cost-effective form of care than institutional care? We believe it is, but we don't have the facts and the figures to back that up and we believe that's something that has to be looked at very seriously in terms of long-term care in the future: some research into hospice forms of care and how they fit into the system in terms of cost as well as in terms of the types of services that are provided.

Having said that, and mentioning those as the concerns that we have in the hospice field, we have come up with some recommendations that we feel are appropriate for looking at how does this fit with long-term care changes.

Number one—and this is in the written brief that I have passed around, but just to highlight—we feel that there needs to be some research on the cost benefit of hospice programs. Unless there's some research into, is this a good idea moneywise, fundingwise and in terms of what kind of care people are getting, then how can we continue to grow the way we are? I think simply the growth in demand for services is a statement that people prefer hospice care, but I think there needs to be some research done into that.

We have a concern that hospice and palliative care are not adequately available across the province for people who need it. I know the Ontario Palliative Care Association was a presenter here earlier this afternoon. Being in similar fields, we do cooperate a lot in terms of trying to promote hospice and palliative care and we share the belief that there are not enough people having access to proper hospice and palliative care in the province, partly because it's not well known, people don't realize it's an option for them, but also because it's not been funded to the extent that it's available for all the people who need it.

2020

Another concern we have is related to that in terms of distance. Do people in the north have appropriate access to hospice and palliative care? I think the answer to that is no. For other types of groups—different language groups, different cultural groups—we know that even

though hospice and palliative care is sadly lacking in the amount of services available, it's even more difficult for people from those special groups to access hospice care.

Another concern we have is the fact that we do have a provincial association that has been established by hospices, that is funded by hospices and fund-raising, and we have a lot of information on hospice care. What's out there now? What's being provided now? Where are new groups springing up? What are hospices doing and where are they? In what 60 communities in the province do we have hospices?

That kind of information could be accessed through our association and, to my knowledge, that's not been used all that well in the development of the MSA model. Certainly we were very much involved in the discussions around the palliative care initiative that was announced in December 1992, but since that time we've had great difficulty in trying to provide information to the people who are making the decisions in terms of the MSA structures and how hospice will or will not be affected by that.

Our final recommendation is that district health councils and others who are involved in planning the MSAs and long-term care reform do access those of us who do know about what's going on with hospice in the province so that we can work together to come up with whatever is the best possible, accessible service for those people who need hospice and palliative care in the long-term care structure. With that, I'd like to stop for some questions.

Ms Carter: I know that in principle the government is committed to hospice care, and we have in fact put extra funds into palliative care. Of course the whole intent of the act we have here is to encourage home care and keeping people in the community as opposed to institutional care, so obviously we're with you on that as well. Also, we want services to be available all over the province, and obviously your service is spreading, but it isn't province-wide at the moment.

For your answer as to how this fits in with the MSAs and how funds will be raised, I think perhaps we should ask the ministry adviser if he would fill us in on that.

Mr Wessinger: Yes. I will ask the policy adviser to provide some clarification with respect to palliative care and the funding aspects.

Mr Quirt: As was pointed out by our presenter, the government announced I think it's \$4.8 million in annual funding to support palliative care initiatives across the province, and that's really divided into three programs.

There's an initiative to provide some training to a member of staff from each long-term care facility in the province and each community services agency each year in palliative care. There's an initiative to provide training to physicians across the province in palliative care as well. In addition, we'll be establishing 14 pain and symptom control teams, which will be a mechanism really to coordinate professional input from physicians and nurses and other people specializing in pain control to make that expertise available to our long-term care system.

Thirdly, we're supporting financially the volunteer visiting hospice programs that have been presented about this evening. That is a very modest amount of money that we're providing to those groups. To date, they hadn't been supported by government, and I believe this is the first time that about 50, if I'm not mistaken, groups will receive some funding support.

That funding support I suspect will assist in just what has been described as the recruitment and training of volunteers. By all means we'd like to see that continue, and I think it would be important for those local hospice groups to be in the decisions about the multiservice agency. It's conceivable that the resources of a multi-service agency could expand that training and support so that even more volunteers are involved in that type of work.

The example was given that some programs don't receive government funding. Clearly it's up to them, then, whether they'd like to have some affiliation with the MSA or continue to go it alone. It's conceivable that the local planning would decide that, "Heck, it's just as simple to continue to provide this grant directly to the group of volunteers and let them continue to do their good work." I think that's quite flexible in providing that modest amount of support.

I would hope the creation of MSAs and the cooperation between MSAs and the visiting hospice programs now will result in more attention to this service and more support in a coordinated way by the existing long-term care resources to the volunteers that are out there doing those visits and that support the people in their last days.

The Vice-Chair: Do you have any response?

Ms Balfour: No, except to say that's exactly the funding that I was speaking of earlier, the palliative care initiative, from which we did receive almost \$500,000, I believe, in the first year for a number of different hospice organizations, and we certainly do appreciate that. Again, it was simply unclear as to how that palliative care initiative fits along with the MSA structure in the future.

Ms Carter: Perhaps the answer is that your group should get involved with the long-term care committees in the regions where they operate, and be part of what is happening.

Ms Balfour: We've certainly tried to do that. Again, I think it's partly because there's not a lot of understanding about what hospice is, what hospice does. I know that in some areas the long-term care committees are very restricted in terms of how many people can be involved, and because hospice is new and small and not seen as an equal player sometimes, sometimes it's difficult to do that.

Mr Quirt: I would recommend that you approach the DHC directly and say, "Hey, we've got a presentation for your long-term care subcommittee on an important program."

Mr McGuinty: Thank you very much for your presentation. I know that some of our members have received your newsletter in the past and have complimented your organization on its quality. I want to at the outset congratulate you on—this is something obviously

that's pure gold. We've got an organization here that doesn't receive any government funding and has grown to the point where it's delivering 60 hospice programs. Everything's done by volunteers, I assume, primarily?

Mr Wessenger: Just on a point of clarification or a point of order: I think it was clear that there is some government funding to the—

Ms Balfour: Let me clarify: There's no government funding to the provincial association. We operate totally clear of government funding. Our hospice members who are distinct and separate bodies who belong to our organization do receive government funding.

Mr Wessenger: Right.

Mr McGuinty: No, I was making reference to the association.

Unless I missed it, what I want from you is your opinion as to how this legislation we're talking about is going to affect me as a consumer. Let's say I was in need of the kind of program which your members offer. Is this going to improve that kind of care, is it going to have a neutral effect or is it going to have a negative impact?

Ms Balfour: I think that depends totally on how it's structured. There are some benefits to this. Certainly, we see that with some government funding we're going to be able to serve a lot more people than we've been able to serve in the past. That's obviously going to make a big difference for us. If people are able to keep the essence of hospice care in terms of who are the clients and how do they reach the clients and can they still provide the same quality and level of service to families and clients in an MSA structure, I think then it will work fine.

The fear right now is there's not a lot of knowledge on how it's going to work. Am I going to be able to keep my volunteers? Who's going to do my fund-raising? Who's going to replace my board in that fund-raising role if the board no longer exists? Who will be planning the policy that the board now plans? Those are the concerns that hospice people have, and if those are addressed in a way that, as I say, allows us to keep the essence of what it is that we provide, I think it could work very well.

2030

Mr McGuinty: How important a factor is the volunteer component among your members?

Ms Balfour: Oh, extremely. As I was saying, most of our programs are primarily volunteers. We collect annual statistics and our statistics for the last year show us that 95% of the people who work in hospice in Ontario are volunteers; only 5% are staff people. So it's absolutely crucial. We wouldn't have a hospice movement without them.

Mr McGuinty: You can't run much cheaper than that, can you?

Ms Balfour: Not much.

Mr McGuinty: Will those volunteers work for a multiservice agency?

Ms Balfour: That's the question. I think it's how it's presented to them. We have volunteers, of course, who have thrown up their hands and said: "I work for a hospice. I'm not going to volunteer my time for some big

multiservice agency." So I think no matter what happens, if hospice was to be part of an MSA, yes, we would lose some, but it depends on how it's approached. If people are still able to volunteer for a hospice program, then I think we may be able to keep them, as long as it's not seen as, "No, you have to volunteer for this big MSA."

ONTARIO HOME CARE CASE MANAGERS' ASSOCIATION

The Vice-Chair: The next presentation will be by representatives of the Ontario Home Care Case Managers' Association. Welcome to the committee. Please introduce yourselves and proceed with your presentation when you're ready.

Ms Marg Kovacs: Thank you, Mr Chairman, ladies and gentlemen. My name is Marg Kovacs, and I'm a case manager with the Hamilton-Wentworth Home Care Program. My background includes home care case management and psychiatric case management, and I'm the immediate past president of the Ontario Home Care Case Managers' Association. With me is Margaret Chiles, a case manager with the Metro Toronto Home Care Program and our president; and Caroline Read, the case manager with the Waterloo Region Home Care Program and our vice-president.

The Ontario Home Care Case Managers' Association is a professional organization. It is six years new and it represents approximately 1,700 case managers who work for the 38 home care programs in Ontario.

Our association is the recognized voice of the Ontario home care case managers. We provide resources to case managers. We promote and develop the role, function and practice of case management and we are committed to partnerships which promote quality service provision.

Certainly over the last few years case managers have seen that there is a massive change and a massive increase in the need for services in the community. The Metro Toronto Home Care Program in 1992-93 admitted 31,280 clients to their acute home care program. That is one of the three programs that they would administer. In 1993-94 the numbers have virtually doubled. In 1992-93 Metro Toronto had about 9,000 registered clients on any given day. In 1993-94 they have approximately 15,000 registered clients on any given day. Social workers do not see little old ladies looking at placement issues any more; social workers are dealing with abuse issues that arise from stresses on families trying to provide care to their family members.

We certainly support this act and recognize that the time for change is here. We applaud Bill 173 in principle. Finally, the ministry has seen fit to embrace a principle that case managers have been practising by for many years. Case management has always focused on the consumer. Case managers utilize a client-centred approach to service delivery, and we have done so for hundreds of thousands of home care clients of all ages who have received home care services for almost 30 years in this province. We will continue to practise in a client-centred manner.

On any given day over 65,000 Ontario citizens are in receipt of client-centred services through the home care programs. What makes home care services client-

directed? It's quite simple. We are guests in our clients' homes. We cannot proceed any faster; we cannot introduce services any faster than a client or a client's family is prepared to accept at that time.

How do we as case managers manage this? We start with a comprehensive, holistic assessment of needs, taking into account the client's strengths, and many clients and families do not recognize the strengths that they have. Case managers draw on their health care or their health professional background knowledge base to ensure that the client's strengths or their level of wellness is maintained, and this is done by providing intervention based on assessed needs.

The case management outcome is the right service to the right client at the right time in the right place. I'll give you an example to illustrate this. I've just recently become aware of an 83-year-old lady who is in receipt of home care services. She has nursing and homemaking for a chronic respiratory condition. Over the last couple of months, her respiratory condition has exacerbated to the point where she can no longer go out for groceries.

This is really a big issue to this lady. She does not see that asking family to grocery-shop is the answer to her problem. When the case manager was making the reassessment visit, the client's solution is, "I will ask for an additional three hours of homemaking for the homemaker to go and do my groceries," and it's \$17 an hour for homemaking. That's a pretty expensive taxpayer service.

The case manager was able to negotiate with the client and make the client aware of a volunteer-based grocery shopping service in her community which will take the client's list, go to the grocery store of her choice and get the groceries. The grocery shopping will be done on a day that the homemaker is visiting, so the homemaker can assist the client in putting the groceries away and starting some meal preparation.

That reassessment ensured that the client's integrity was maintained, that the new needs were identified and they were met without an undue burden on human or financial resources. Assessment and reassessment by case managers have a major impact on the outcomes of a client's feeling of wellness and service utilization.

The role of the case manager is not well understood in the delivery of health and social services, and it is undervalued. Karen Goldenberg, the special adviser for MSA implementation, acknowledged that "of all the misconceptions and inaccuracies that arose during the long-term care consultation...the role of the home care case manager was least understood." She stated later on that case management was an essential function that was played by the home care case managers and would continue to be played in the multiservice agency.

The ministry's previous documents on long-term care included case management as an acknowledged core function and service of the multiservice agency, but now Bill 173 has come out and there is no mention of case management anywhere.

Section 2 of the act lists four types of services as the mandatory basket. They are community support, home-

making, personal support and professional services. Case management is a professional service and it is provided by health care professionals who are dedicated to that role with dedicated time. It is not a role that can share time with that of direct, hands-on service provision. It's far too time-intensive.

There are six key functions of case management: a holistic assessment, service planning, service coordination, resource management, reassessment and alternative planning for changing needs or on discharge, and these case management functions ensure that there is a consistent accountability. The buck stops with me, the case manager. There is a decrease in fragmentation of services and there is a decrease in inappropriate service utilization.

The core functions, skills, knowledge and experience of case managers receive lipservice from the ministry, and yet the vital role of case management has been acknowledged and included by the ministry in previous long-term care documents. The ministry has embraced the case management principle of client-directed services in this legislation. The ministry must embrace the role of case manager in this legislation.

2040

Ms Caroline Read: I would like to make some summary comments and some recommendations on behalf of the Ontario Home Care Case Managers' Association.

We acknowledge the need for philosophical and practical system changes.

We remind the ministry that the expertise, the skill, the mandate and the knowledge base required for assessment and service coordination currently exists in 1,700 practising home care case managers. At this table the three of us have almost 70 years of community service, many of those in home care programs and case management delivery.

We would like to see the assurance for citizens of this province, as the home care case managers embrace already, that consumer rights to participate and decide service plan needs is the essence of the current case management practice; that indeed it is client-centred, that it is goal-oriented, that it is multidisciplinary in its approach; and that service coordination is actually only one component of case management.

The association suggests that previous system-based restrictions led to decreased consumer lack of control and input and the current misunderstanding of the value of case management. We would like the ministry to acknowledge the need to better inform our consumers about the functions and not get hung up on a name.

The association acknowledges that this province is unique in its population, its size, its geography and its resource extremes, and the need to ensure that local district health councils provide direction and facilitation pertinent to the community's needs and resources is paramount, thereby increasing the equitable service across the province while allowing sufficient flexibility to meet local diversities and needs.

The association requests that the ministry acknowledge

that case management, as a model of service delivery, is valued throughout the world and must be included in the Long-Term Care Act. We would point out to this committee that case management, internationally, is really growing at an alarming rate in terms of its acceptability, its practice, its research.

In Toronto this September there is an international conference on long-term care case management. Canada, the United States, England, South Africa, Israel, Australia and New Zealand are all presenting at this international conference, where case management is the focus.

Nationally, the Canadian Home Care Association has submitted proposals for research projects on case management. Case management in the United States is far ahead of Canada, and it is really only in the last six to eight years that case managers working in home care programs have felt empowered and found their personal volunteer time to pursue the practice of case management and to promote it.

We would like to recommend to this committee:

—That decision-making be based on both public response and serious consideration of research-based data and evaluation. It is our concern that much of the input in terms of public response has been purely anecdotal, and to this point in time there has been very little Canadian research done on case management. We would just caution that the ministry not throw the baby out with the bathwater;

—That case management be designated in the legislation as a core function and be delegated only with caution in specific consumer need and service situations; that there are appropriate places and times for single-service case management and for consumer case management; that the current case managers are also aware of those very existences but have not had the flexibility, because of legislative strictures, to provide that flexibility to the consumer;

—That designated case managers are identified to ensure consistency in screening and assessment, knowledge of resources—I would just share with you that in Waterloo region alone, where I practise, there are over 1,000 community resources which case managers are fairly well informed about and share with their clients—consumer access to resources, service coordination expertise, and evaluation skills;

Therefore providing the very accountability that the ministry seeks.

The case managers' association is pleased to have had the opportunity to address this committee and we trust that you will seriously consider our recommendations and our concerns, and we would be happy to entertain any questions.

Mr Wessenger: Thank you very much for your presentation. I note your concerns about the function being set out in the bill, and I'm advised that section 20, which you should refer to, sets out the function that makes it in fact the obligation of every approved agency in effect to assess a person's requirements, determine the person's eligibility and develop a plan of service. I suggest that that really sets out as a core, as a require-

ment of every approved agency, so in effect case management is set out as a core obligation of every approved agency.

Ms Margaret Chiles: If I could respond to that, it identifies the functions of case management, but it doesn't identify that it is a case manager who does it. It's up to the MSA to decide who would do it, and without any direction as to who will be doing that function of case management, you could end up with the cleaner doing it.

Mr Wessenger: I think I'll ask our policy adviser to respond to that comment.

Mr Quirt: It certainly isn't our intention that the cleaners would end up doing the case management and I think, as you've pointed out, that the bill does try to reflect the importance of the assessment of individuals' needs and the development of an appropriate service plan involving the client, and the monitoring of the effectiveness of that service plan and the development of alternative strategies if those original strategies don't work.

May I also point out that the experience and skills of the home care case managers across the province may be regarded as perhaps one of the most important building blocks for the new system. So in no way are we trying to imply by not mentioning case management specifically in the bill that those services aren't a necessary and important part of the new MSA system and that the people who do it now aren't an extremely valuable resource that we need in the new system.

The potential is there, however, that for the MSA to organize its service delivery activities in a way where the appropriate professionals involved at the right time to do assessment—it's conceivable that for some clients the case management assessment might be a very short assessment process. If someone just needs a ride to the doctor, it may be a very short conversation and a volunteer dispatched. In other cases it might be appropriate that a social worker who had familiarity with the particular social needs of a particular client might assume the case management responsibility for that client.

We know the background of our home care case managers is almost exclusively a nursing background, and that's a very important set of skills and background for that job as well. We haven't ruled out the possibility that in some MSAs a worker may have, in addition to case management responsibilities, some direct service provision responsibilities as well. We're not saying that you can't do that. We're saying that probably both models might be tried, and it might vary on the basis of geography, for example, how best those services might be configured.

I know some of our staff said, "Well, where's the term 'case management' in the bill?" and we ran into the issue of the difficulty of defining what case management is for a variety of different clients. I think you've pointed out quite rightly that the bill doesn't give the reader the correct impression, because the bill, to a reader not familiar with our intentions, might imply that we don't think case management's an important service in its own right. We know that it is, and the presenter just before you talked about how intensive case management can be

the difference between someone staying at home and having to go to a facility.

I think we're on the same wavelength. I think it's a question of making sure that the wording of the bill reflects their intentions. Certainly the skills that you people contribute to the system are recognized and we need you as an ongoing part of it.

2050

Ms Read: I thank you for that acknowledgement. It's important, too, to remember that there is a tremendous growth in the acceptance of case management. Much of what is misunderstood about case management has been due to lack of resources to inform the consumers.

At this point in time, as we're about to change much of our system in terms of access for certain—I think it's very important that we also share with the public the functions that the MSA provides and explain those functions and terms to them. I would hope the ministry is planning to provide the financial resources to inform our clientele. It's pure folly to think that they would be any better informed with a new system than they are presently without that kind of information sharing.

Mr Quirt: We recognize that information provided to the client in an understandable way is a difficult thing to achieve, and it's an important service that we'd like to improve on. Part of the problem with the existing system is that with the fragmentation of the system and the variety of different workers and agencies sometimes involved, it's sometimes difficult for one worker to really understand what all those other agencies are involved in, and it's sometimes difficult to have a coordinated approach among a number of workers if their mandates are a little different or if the provincial rules are a little different.

You would probably agree with my perception that the role of home care case managers has been constrained more by provincial policy and restrictions than it has been by the willingness or the skills of the workers out there doing the job. What we're trying to achieve with the multiservice agency concept is the freedom for an interdisciplinary approach to services so that you can sit around the table with your colleagues and decide how your agency can best respond to somebody's needs, rather than being on the phone to four other agencies to try to figure that out.

Mrs Sullivan: I heard this afternoon I think the parliamentary assistant or counsel refer to section 20 of the act as the case management vehicle, because this has been raised in another presentation. I note that you indicate case management should be included in the list of professional services. My concern, on re-reading section 20, is that section 20 describes a series of tasks that don't imply an integrated case management function. In fact, it really only describes, first of all, the assessment and eligibility, which may or may not include a clinical assessment. It doesn't even give an indication of what has to be assessed and what the eligibility criteria are. We know those eligibility criteria are going to be developed through the regulations, which somebody will see some time.

The other thing I think is of concern is the structure of the bill itself, because we have, first of all, the definitions of the items that are community services. Then we have, in another couple of sections further back, a description of the multiservice agencies. Nowhere in the description of the MSAs is the role of the case manager described or the functions of determining eligibility or assessment and so on. There is an indication that the minister may designate an approved agency as an MSA.

Then we move to section 20 and we find that the case management function applies to an approved agency, which may or may not be an MSA. Maybe counsel should look at this. Are all approved agencies MSAs? If they're not, is this only the transition period? If this is only for the transition period, then the whole point about section 20 being the case management issue is moot, because then it doesn't exist for the MSA. Do you hear what I'm saying?

Mr Wessinger: I think I'll ask counsel to respond to that.

Ms Czukar: There are really two points in relation to that. One is yes, partly it's to accommodate the transition period that the requirement is imposed upon approved agencies, so that those agencies which currently provide the case management function can continue to do it under the bill, but also to impose a requirement on every approved agency to do this, to assess people's needs, to come up with a plan, to involve the person in developing a plan, to reassess needs as required and to implement changes in the plan when required. So it's a flexible provision. Most of the provisions in the bill are flexible in order to accommodate both the existing system, the transition to the new system and a flexible new system. That's why it is where it is.

Mrs Sullivan: Maybe it should be improved.

Mr Jim Wilson: I would concur with Mrs Sullivan that it is extremely confusing, the way the bill is written. It's almost laughable if it wasn't such a serious topic.

I want to thank the group for its presentation. You've brought forward some points that needed to be said, because the key to this whole thing, as far as I can tell, is assessment. I'm going to try again here to get a clarification from the government. The way the bill is written, clause 20(1)(a), the very first thing, of course, that has to be done is to assess the person's requirements. It's the key to everything, yet it's very unclear to me—and I've been Health critic for four years and seen lots of legislation that's unclear, and here we are again—as to what the heck you mean by that. Who's going to do the assessment? I understand it's about a 23- to 26-page assessment document at the moment, which I hope you whittle down to something more reasonable.

Here are some clear questions: Is it going to be up to each MSA or are there going to be provincial standards on who fills out the 23-page document? What type of professional or otherwise will be required to do that? Back to who. Really, don't tell me this is all going in regulations, because my caucus just may have to remove ourselves from this bill, which would close down the hearings, waiting for your regulations, because I'm not voting on another piece of legislation around here where

I don't know what I'm voting on.

Mr Wessenger: I am going to refer that to a policy adviser, but I can assure you there's no 23-page assessment form to be filled out.

Mr Jim Wilson: That's what somebody on the committee—that's someone on your own committee.

Mr Wessenger: No, there's no such assessment form.

Mr Jim Wilson: It was 26; we're down to 23.

Mr Wessenger: No, no such assessment form, I can assure you that.

Interjection: Thirty-five?

Mr Jim Wilson: Oh, it was 35? Maybe you should talk to the committee members I met with at lunchtime.

Mr Quirt: Let me first of all point out that there's no consensus among the community providers that we're consulting with on whether in fact there should be one provincial standard assessment form. There is a consensus, I think it's fair to say, that there should be a consistent assessment process or approach, because the community providers' coalition acknowledges the need for the new system to treat people fairly, so that if you were assessed for a range of programs and services in Kingston and moved to Oshawa, you wouldn't all of a sudden not be eligible for something, or be eligible for a whole bunch of things one place you wouldn't be somewhere else. Determining who's eligible for how much requires people to ask similar questions so that a fair identification of their needs can be made one place to the next.

We were under the impression that a number of people felt that one consistent assessment form was a good idea. We certainly proposed a work group to take a look at a form that's been in existence since about 1989 or 1990, developed by the office for senior citizens and somewhat improved since then. Our advisers have cautioned us that no, maybe a consistent form isn't necessary, that perhaps just consistent service definitions and consistent data gathered and consistent topics covered in an assessment process might be an adequate set of tools to ensure fairness and consistency in what people are eligible for. So we'll continue that work. That work's under way now with our advisers.

2100

Who does the assessment? That would vary in accordance with the type of service that someone requires. For example, if someone was to call the intake worker at an MSA and say: "Hey, I understand you've got volunteers who provide rides; I need to go to the doctor next Thursday," then it may well be that a 30-second conversation is necessary to dispatch a volunteer and that's the end of it, and the assessment information would simply say, "Mrs Smith, on such-and-such a street needs a pickup," and that would be the end of it. The assessment form that had been developed, and it's under discussion now, was certainly very modular in its approach so that for some clients you'd never get by the first five lines on the first page.

For others, for example, who had a more complicated range of needs, it may be an assessment that's done by a specialized nurse who is aware of the best approach to intravenous pain control in the home, for example, and

there would be a very in-depth assessment that would be done collaboratively with a physician and a nurse to determine how best medication might be provided to that client, and it would be quite an involved assessment that may involve a multidisciplinary approach.

The form, as I understand it, is not 23 or 25 or 27 or whatever pages long; there's a policy paper, a discussion paper about assessment and intake and questions, that's probably about that length, but I don't think the form itself is that long. I stand to be corrected, but I'm advised it's not that long.

As I said earlier, we may not have a consistent form, because when we talked to people from the Ontario Community Support Association and from the Ontario Home Care Programs Association and from Saint Elizabeth's and from other community organizations, the VON, for example, they're cautioning us, "No, you don't have to be that prescriptive to say one form is necessary." So we continue to meet with these folks to talk about eligibility criteria and their relationship to what information you need to make a decision, what type of process happens within an MSA with the intake worker, and then, when it is referred to a case manager who really has to apply his or her professional skills to develop the most appropriate service response, and whether we end up with a consistent form or not is an open question at this point. The only way we'd end up with a consistent form is if there was a consensus among our partners that said, "Yes, this is a good idea."

Ms Read: Perhaps I might just make a couple of comments around assessment, please.

I think we would agree, as case managers, that there is a place for screening and there is a place for assessment. Certainly, when a caller calls in to an MSA, if they request a ride to their doctor's, that is definitely something that can be handled through a screening contact. However, there is an assumption that for most people calling in to the MSA, from what I have read in the documents, the individuals will know what it is they need and they would ask for nursing or they would ask for homemaking. I think that's a false assumption. It takes very skilled case management to determine, through a holistic assessment, exactly what the need is.

A frail elderly senior who lives alone who contacts us because they're having difficulty lifting the vacuum cleaner—and this happens regularly—may in fact have many more problems, and that is really the tip of the iceberg. They just know they're not coping any more. It is only since the integrated homemaker program came along that we have had the ability to assess, by virtue of the lack of a physician referral requirement.

Now this particular lady, and I am thinking of a particular case, was an accident waiting to happen. We did go out and do a home assessment. She in fact had scatter rugs throughout her house. She lived in an old two-storey with a bathroom on the upper level only. She was not able to cope, and it was only through a very detailed OT assessment that we were able to make some modifications in her home to help her manage in a very appropriate manner for a considerable length of time.

My point here is that case management is able to

determine those needs because of their highly skilled assessment, and that not everyone is able to do that. Not only that, but we do not have a disease focus, as many of the single-discipline providers do.

In terms of a standardized assessment tool, a number of years ago we were working on a one-stop access tool. It seems to me that the ISQ has not moved terribly far away from that and we are still looking at an extremely lengthy document.

The other thing I would like to say is that we acknowledge that consumers do not wish multiassessments. We feel, as case managers, that we have assessed people to death, and we would love to see something that minimizes the need for overassessing.

However, there is always the place for the single-service provider whose area of expertise is very definite. I am not going to go in to do an assessment and ask them what their range of motion is in their extremities; however, a physiotherapist or an occupational therapist may well do that. So there is a place for the specific beyond the holistic, generalized assessment.

It's really important for us to remember that hands-on service providers already have waiting lists. We are expecting them now to add to their tasks case management functions. We are also expecting them to be available and accessible to the consumer if they are a single-service provider. I'm not clear, from the documents we have received, how that is going to happen. We don't want to suggest that it cannot be done, but we do not see what the process is going to be in developing that single-service provision.

We're also concerned about passing the baton of case management, if you will, as a client's needs change. We often start with the acknowledgement that there is a single service need, and we provide the service to meet that need. But after that person has been reassessed in their home environment following a hospital discharge, in that environment we can see other needs that must be met, and then we pass along to the physician the request for additional service and other service providers become involved. Do we pass the case management baton from one provider to the other? When all of our goals are met, do we pass it along then to the homemaking or to the personal support? It is very confusing in this document.

Mr Quirt: I can appreciate the confusion you've expressed. You've made a very articulate argument in favour of the benefits of case management, and I agree with what you've said. I was certainly only trying to point out that the assessment of an individual client might range from a very brief discussion about a single service to a more complex, in-depth assessment involving the professionals to which you've referred. One of the benefits that advocates of the multiservice agency see is the benefit of that multidisciplinary team working more collaboratively, closer together, without the issue of, "When do I pass on lead responsibility from one agency to another?"

You've talked about the multiplicity of assessments. I think you'd have to agree that some clients express frustration from time to time if in fact they're assessed by a home care case manager and you decide it's appropriate

that a physiotherapist and a nurse and a homemaker visit. It's conceivable that three different agencies are going to go out and see the person you've assessed, and it's conceivable and understandable that each of those other three agencies is going to have to, even with your best efforts to inform them about the needs of the client, do their own form of assessment once they get there.

We think putting professionals with good intentions together in a team in a multiservice agency-multidisciplinary setting allows you to collaborate better, understand your client collectively better and deliver a better multidisciplinary service as a result.

Ms Read: Perhaps I live in a very fortunate area. I think in my own program we practise that way now. We are not all under one roof. We do case conference, and that is one of the tools case managers use, and we do meet and talk on a regular basis and receive written reports when there is a status change. I think we already do look at the multidisciplinary team approach and we do share those reassessments by the provider.

Mr Quirt: I don't think we have a disagreement, then.

2110

EAST YORK HEALTH UNIT

The Vice-Chair: Next is the East York Health Unit. Welcome to the committee.

Mr Michael Prue: My name is Michael Prue. I'm the mayor of East York, and I'm here today with the medical officer of health, Dr Sheela Basur, and Pat Thomas, the director of adult health, and Janice Leet, a community health nurse.

I'd like to commend the committee and the staff, and perhaps the government, on finally taking some action on this. I was reminding myself today that more than 25 years ago I used to come down to the Legislature when I was a student at the University of Toronto, and I heard many passionate debates on the need to reform health care, particularly for the aged. I hope somebody's finally going to get to it, sooner or later, some day, somehow. This is the best attempt I've seen as a watcher for more than 25 years.

A little bit about the demographics of East York. It's one of Canada's oldest communities; next to Victoria in British Columbia, we are considered to be the oldest community. We're the home of some eight seniors' homes, and the average age is among Canada's oldest. We feel that the future for most of Ontario is already in East York. As the population ages, as people live longer, as the housing stock and everything that is Canada continues to happen, it's only a matter of time till other communities have 16% to 25% of population over age 65.

East York has embraced Bill 173, and we have tried as best we can to work along with the government and those who are supportive of long-term health care reform to give it a community focus. We believe we have the kind of experience and the kind of knowhow in East York that will make it work. We welcome the initiative, and I have spoken publicly at Metro council in opposition to those who think this bill is not the way to go.

We believe that dealing with the elderly is something that must be done and must be done very quickly because (1) it's getting very expensive and (2) we don't believe the level of service is as high or as qualitative as it could be.

We have attempted in East York to have one-stop shopping, which this bill proposes to do, and I can see that some of the people are looking at the brochure we have produced through the health unit. There's one-stop shopping, or actually two-stop shopping. We have two major locations that hand out this information: the Neighbourhood Information Centre, which is in the easterly part of East York, and the Thorncliffe Neighbourhood Office, which services the westerly portion. People can go there and get some kind of referral or an idea, with someone to assist them, in looking at all these agencies and what they can do.

The borough of East York has also been very instrumental in setting up what we call a community action team, CAT for short. This is a team of health care providers, the police, public health officials, community development council representatives, Community Care East York representatives for the elderly, who can and will go out to homes where there's an identified problem, whether the problem be abuse or alcoholism or just a house in a run-down condition, and go out and make the necessary recommendations to council or to the appropriate agency to deal with it.

We feel we've had a great deal of success, and we are here to support the bill, with some modifications—always with some modifications. I'm going to turn it over to Dr Basrur, who's really the expert in this, to talk about the modifications. They are in two areas: one is dental and—the second one won't come to me, but she'll do it right away.

Dr Sheela Basrur: You'll remember it in a very quick second. I'll briefly walk the committee through the recommendations, which are on the preface page. Some of these have already been addressed in preceding deputations, so I won't go over them in detail.

The first is a plea that the regulations governing eligibility criteria, client assessment, service delivery and additional services of any sort provide flexibility and room for interpretation because of the diversity of needs that we see in the community. An example of the diversity will be described shortly in a typical scenario that we often face.

Recommendation 2 really pertains to the programs you've heard reference to, called client intervention and assistance, or CIA, programs. I didn't mention them specifically in the brief because I felt this was a program funded exclusively in Metro Toronto up until now, and I wasn't certain if the committee's mandate was to look at province-wide application or whether you would be able to look at local variations. We would make a very strong plea that client intervention and assistance programs continue to be funded and, if anything, expanded across the province, if that's possible.

I've heard support for CIA being implicit in sections 20 and 21. I've not heard whether the funding that's currently given to Metro will remain in the system for the

same purpose, and we request clarification of that.

The final recommendation regards the addition to professional services of basic dental care. We'll describe in some detail what it's like for seniors in the community who have absolutely no access to dental care and what it might be like if they had some.

Let me also make the point that the health unit is here truly as a neutral third-party observer, and we're in the unusual position of asking to give up some of the work we're currently doing. We feel that some of the work we're doing in the area of seniors is better done by an MSA, and rather than us continuing to work on the fringes, we think the MSA ought to really be one-stop shopping for everything in a full, diverse range of needs, and not to have public health, at least in East York, continuing to dabble at the fringes for lack of another provider to step in and fill the breach.

If you would turn to the bottom of page 2, I have outlined one of the situations that has been at the forefront of our minds over the last couple of years. The committee may recall the widely publicized death of an elderly woman—her name was widely published; it was Muriel Smith—who was found dead in her house with claims of no heat, no water, no hydro, no food, and terrible, terrible living conditions: garbage and excrement and old food and bags piled to the ceiling in every room, if one could even gain access from one room to the next. Her body was found in the house a few weeks after she had died—very, very terrible conditions, and it caused a tremendous level of concern in the community.

It was a political problem. It was a community problem. It was an organizational, administrative, legal problem for all the agencies that had been involved with her. That included the health unit, other community support agencies, the police, the fire department, bylaw—you name it. People had been in and out of her house, or at least her yard, for years, and no one had been in a position to prevent her death. Whether it was preventable or not, we'll never know, but it wasn't for lack of trying, and yet this person still died.

We've been asking ourselves since that time, was there something that was missing in the current system that could be provided through an MSA? If there is, let's identify that and please make sure it's in the reformed long-term care system so we don't have more of these people happening.

I guess our concern is that these aren't isolated cases; we saw the tip of the iceberg in that one instance. Ever since that awareness has been heightened, we've been getting call after call after call from concerned neighbours, concerned family members, from police, hydro workers, Consumers' Gas, anyone who goes into a house and sees a person living in very terrible conditions and says: "Oh, my goodness, this person could die before I get back in the next time. I'd better phone somebody. Who do I call?" They don't know where to call. They phone public health.

This is clearly not a preventive step we can take. It's certainly not health promotion. At best, we're preventing someone from dying prematurely. We don't offer an emergency support service of the type the person needs.

They're at a crisis that might have been preventable had there been some kind of intervention before that, long before that, and public health is not in a position at this stage to offer that.

2120

There is an agency we work with known as Community Care East York. They have a CIA or client intervention and assistance program. If they know about a case like this, they will go in and assess the person, and if they're not immediately signed on for however many hours of homemaking or the like, they'll continue to go on an outreach basis, just making sure that the person's needs are stable or that they haven't changed their minds about what they might want or accept on a given day. They are supportive, but they don't give up on a person just because they say no in the first instance.

What we are concerned about is that the draft bill under section 20 really assumes that the person is able and willing to pick up the phone and access services. In fact, the section opening on section 20 is, "When a person applies to an approved agency for any of the community services...." "When a person applies" implies that someone is ready and able to pick up the phone and knows what that one number is etc. Often these people literally can't get out of their house, and they may or may not be consenting; they may or may not even be competent. It's very difficult to even get in and assess what their needs are or whether they're in an emergency or just an urgent or chronic situation.

It needs more than one perspective, I would say. Thinking of the preceding presentation, it really needs a multiple approach: at minimum, a nursing and a social work perspective jointly. What we've described in our brief is an outreach team, without trying to prescribe what professionals or others might be included in that; some constellation of people who have a range of skills and perspectives so that any need within that diverse range can be met.

I would also say that there has been some assumption that the solution to some of these community situations will be the Advocacy Act and the Substitute Decisions Act. I'm familiar, from some of my previous discussions when the Muriel Smith case was at its peak, that those acts will not provide a substitute for the kind of service delivery we really need here. The advocacy system will allow rights advice to be given and consent to be confirmed or denied and the Substitute Decisions Act similarly will provide a range of alternatives in the event that the person is incapable of giving consent, but it doesn't substitute for someone knocking on their door to see how they're doing and being able to provide a response when they come to the door and are obviously in a much more precarious state than anyone ever imagined. That kind of service is still needed.

At this point, I'll go to the dental care example that's on page 6. We get a number of calls like this. We've said about four calls per month, but that's absolutely the tip of the tip of the iceberg, I'm sure, because our dental staff don't offer service to seniors and we don't really even publicize it. Somehow people make the mistake of phoning us and we write down how many calls we get,

and we get about four a month. If there was any modicum of service we provided, I'm sure the number would skyrocket.

The example given is of a woman who's got multiple medical problems. All of these may be picturable by the committee: excruciating toothache pain for over a week, on top of diabetes, high blood pressure and what medications she might be on for all of those; very little income, going to food banks, and can't afford to get her tooth pulled because, at minimum, with our assistance, it might cost her \$50 or \$60. And if she goes to a dentist or goes to a hospital, if she feels it's an emergency or some good Samaritan takes her, she'll be presented with a bill for up to \$200, and no one will know whether it's at the bottom or the top end of that range until they've actually gone in and provided the service. In other words, there's no free estimate, in terms of our experience, with providing dental services.

We feel that this is really a disgrace, that people who have lived all their lives in this society, in any society, ought to have freedom from pain, at the very least, and not be made to suffer under inhumane conditions. Right now people are suffering because of a lack of even emergency dental care. Forget basic dental care—not even emergency.

As I've said, there are many other complications that can ensue from poor dental health. There's chronic pain; risk of infection, and that can be either localized or it can generalize to other parts of the body; substance abuse; poor nutritional status; reduced interaction with others; and possibly premature institutionalization. These are not beyond the realm of possibility at all. They happen on a regular basis in terms of what comes to our attention.

I recognize that the staff and the decision-makers in the long-term care consultation process have had to make some very difficult choices as to what's in the basket of services and what's not, so personally I'm not optimistic that you'll turn around on a dime and include basic dental care within the basket. However, we do feel that it needs to be mentioned again and again and presented as an opportunity for someone to do something about. If it took Mayor Prue 20 years of coming to Queen's Park, I'm still young. I can come another 20 myself. I hope it wouldn't take that long.

Perhaps I'll stop there and ask my colleagues if there's any further points to make.

The Vice-Chair: Any other presentations? If not, questions.

Mr Malkowski: Thank you to the presenters, Mike Prue—mayor—and Dr Sheela Basrur. I really appreciate the representation from my own community of East York and I think it is important to recognize that we have such a high number of seniors, as well as a high number of disabled people, in the community. I've seen this community being real leaders in this area in terms of having the courage to make very difficult decisions and to develop a very courageous plan to meet the needs of people in the community. I'm very impressed with the leadership that I've seen in terms of pulling key members of the community together. We've seen the East York Health Unit and Community Care East York working

together. This is a real model of excellence, I think, and it in fact reflects a real community spirit where we're seeing the interests of consumers in the community really being reflected.

The legislation that we've developed, just in terms of your own experience, we've just begun this development, and yet already we see you as being a model of excellence in terms of being able to pull a community together. In fact, the district health council of Metro Toronto has identified East York as a model of excellence and an area for an MSA.

Maybe you could tell the committee what type of improvements you would identify with the establishment of an MSA in East York. What do you predict in terms of improvements in services compared to the situation as it presently stands, and how do you see an MSA actually changing services and improving them for your community?

Dr Basrur: That's beyond the scope of my prepared deputation, but I'll give it a try. The proposed benefits of the long-term care reform are outlined in the bill and all of the companion documents, and personally I would foresee that the vast majority of those would apply in East York as they're expected to throughout Ontario. If anything, I would see that East York provides more fertile ground for the development of a proper MSA and long-term care system than in other areas because we are small. I think small is pretty great, as opposed to being inefficient. It's very effective. People work together, they know one another, they trust one another and they're willing to come together in the same room on the spur of the moment and work together in a very collaborative way.

I mean, the fact that this booklet was produced by 26 different organizations—I'm not talking members, I'm talking different governing structures—they all got together and pooled their resources for the purpose of promoting a common good. That's tremendous, and that was achieved within, what, six months? That speaks a lot to the willingness of our community to work together.

My hesitancy to answer in detail is that I'm not contained within the basket of services and I wouldn't want to comment on how other organizations are going to reorganize their governing structures and their services and make predictions about that. All I can say is that I see a tremendous amount of willingness. I have been involved in a number of the meetings for planning the services, and there's a constellation of local agencies working with the Metro-wide ones and will be, as was mentioned earlier, applying for planning dollars to put a proposal together.

2130

In terms of benefits for the community, I have a feeling that it would be a way of galvanizing community involvement in services for seniors in a more consolidated way. I think there's a lot of volunteer activity and community interest in the specific programs operated by various agencies that are really too numerous to mention. There's a lot of community involvement, but perhaps there can be an even greater outcome if those energies are pooled towards a common goal. I don't see it as

creating a bureaucracy; I see it more as harnessing those energies and really making them that much more productive and effective.

Mr Prue: If I can just add, the one thing that's been really unique is that the agencies in East York themselves have taken the initiative. This hasn't come from the health unit or from the political structure; it's come from the agencies themselves. Our community development council, which is our social planning agency, and most of the seniors agencies have come down and they have decided that the MSA is the way to go. We really bow to their expertise. They deal with the people every day and they believe that, by coming together under the umbrella of an MSA within our community, they can better serve those people. So they are supporting it and therefore we are supporting it.

Mr Malkowski: If I can just have one final question, one thing I have heard again and again, especially from some opposition members—specifically, I think, the Conservatives have said this over and over again—is that there are some real concerns that the establishment of the MSA is just going to be one huge bureaucracy and the creation of more bureaucracy. Yet what you're saying is the complete opposite, that these in fact are unfounded fears.

Could you just tell us how you see the community responding to an MSA and do you think this is a model that could be used throughout the province, and that we should not be fearing the creation of a new bureaucracy but that you're seeing an agency that would serve the needs of the community and that maybe some of this concern and confusion can be distilled because what you're saying is more solidarity in terms of the various agencies? How does East York feel about this?

Mr Prue: It is difficult to speak for other communities. East York is a large community in terms of Ontario, but it's the smallest community in Metropolitan Toronto. Certainly some of the other communities in the GTA are larger and have different problems.

Our size is unique at 100,000 people. It is unique that we can deliver a kind of service and know the community very well. I don't know whether this will work in every community right off. I would be more than prepared, and I think all of our social service agencies would be prepared—if you want a community to pilot it, we would be more than willing for you to let us pilot it and see where it's going and how it needs to be improved before you go out to either larger or smaller communities. We think our size and the large numbers of seniors and our history of being able to look after them for so many years makes us an ideal location. I can't speak, and I won't speak, for every community, because I don't know how they'll be affected. I don't know their structures. But certainly our structure lends itself to it and we're looking forward to it.

Dr Basrur: May I also add to that response that as a bureaucrat, I suppose, I have not heard anyone speak in favour of creating a large bureaucracy. Everyone—if there's one point they're agreed on, it's no one wants a large bureaucracy. So I have a hard time imagining how, against all of those efforts, we'd still wind up with 42 big

bureaucracies that nobody wanted. It just doesn't seem plausible to me that all the energy and paper it takes to create a big structure would happen despite everyone's best efforts.

Mr Prue: Welcome to government.

Dr Basrur: I'm young, like I said. Give me 20 years and I'll understand.

The second thing I would say is that, in my own experience, there can be a lot of personal flexibility and choice and control for consumers, which is how the consumers will ultimately view the success of MSAs. That can be achieved depending on the internal organization and corporate style of the governing board and of the management team and the way in which they organize their services. If they choose to see things not in a hierarchical pyramid with someone at the top and a bunch of people at the bottom, then I think it speaks very favourably to an organization that will be able to respond to diversity. It must respond to diversity, and there's absolute agreement that it needs to among all of the service providers. So again, if there's that kind of universal willingness to see that end through to completion, I'm pretty hopeful that it'll get there.

Mr Malkowski: Thank you very much for your presentation. It was certainly full of excellent facts. I know the Ministry of Health has in fact targeted East York as a real model, having seen that agreement reached by the district health council of Metro. So I would like to thank you for the leadership and for sharing this model of solidarity with the community, and I wish you luck in continuing to meet the needs of seniors in East York.

Mr Jim Wilson: I should say to the presenters and to Mr Malkowski, I'll take your word for it that you need an MSA in East York. If I were Mr Malkowski and my medical officer of health and his worship the mayor were so in favour of an MSA, I'd be fighting for them too. It does lead me to a question, though, and perhaps another comment.

You're the only health unit that I'm aware of in the province that isn't actually fighting to become the MSA. That's the debate and wars that are going on in the rest of the province. I know in Simcoe county, for example, they're constantly meeting with me and sending us letters saying, "We better be the MSA because we have all the resources now." So you might turn out to be unique in that area.

I do want to know what the feeling of your employees is, though, at the health unit. You, I assume, are carrying out many of the functions that an MSA would carry out now and there will be displacement of jobs as those people, I assume, would have to go work for the new bureaucracy. Has there been a discussion? You being the chief medical officer of health, an advocate on behalf of the staff, how do your nurses etc feel about this?

Dr Basrur: First of all, with respect to the interest of other public health units in becoming the MSA or at least expanding their mandate to include all long-term care, I think that pertains exclusively to the health units that operate home care programs, and not all do. None of them in Metro do, and outside of Metro there is a small

number that do not provide home care. I wouldn't try to name them for the committee, but they do exist. There will be a brief submitted, I believe, on August 24 to committee from those with home care programs, and they really would speak for themselves. Even if—well, I won't speculate. So that's why we're not getting involved in the governance issue. I think if someone else wants to figure out how to make the new system work, I'll wish them well and we'll work together.

Mr Jim Wilson: That's a very honest response. We're still trying to figure it out here, so—

Dr Basrur: Secondly, with regard to worker displacement—

Mr Jim Wilson: I'm sorry, I must correct myself. I assumed—I didn't know in Metro that you didn't deliver home care, for example.

Dr Basrur: That's right. There's the Metro Toronto Home Care Program. That's a big bureaucracy.

Mr Jim Wilson: That takes them all, yes.

Dr Basrur: That's a large organization which covers Metro Toronto. Although the Health Protection and Promotion Act outlines home care as one of the public health programs and services, it's not in Metro.

Mr Jim Wilson: Oh, okay. So you likely won't have much of a displacement with staff at all.

Dr Basrur: Displacement per se, no. But as I said at the beginning, there are some functions that our public health nurses do that we would like to turn over to the MSA, and maybe on that note I'll just ask Pat and Janice to say a few words.

Ms Pat Thomas: Just in reference to that is going back again to the whole area of where we get the crisis intervention calls at 3:20 on a Friday afternoon and, "What are you going to do and how are you going to help this individual," it's the individual who is not connected to services, perhaps doesn't wish those services initially, and needs some intervention in order to stabilize their risk situation to an acceptable level, and who is going to do that? We do not clearly see that at the present time outlined in Bill 173. It may in fact be part of case management, is an important role of case management, but from the writing of the bill, it looks like it's when the person is already a part of an MSA or has the ability to outreach themselves. There are many, many clients in our communities who are not able to do that.

Traditionally, public health has been one of those agencies receiving those kinds of phone calls, doing those kinds of assessment and coordination of services.

2140

Ms Janice Leet: I would just like to say that, being a community health nurse, for the last five years since Community Care East York has come into being we have been able to feel very confident at referring seniors and care givers to another agency. Therefore, our primary concern is primary prevention. That's why the community resource awareness committee was formed, because the 26 agencies in East York servicing seniors and disabled adults have identified the main problem for seniors and care givers as how to access services. So we're putting our energies into population base, reaching as many

people as we can to assist them in finding the resource, but without necessarily calling us, ie, the pamphlet. But that's where client intervention comes in, and that's where we need it in the MSA.

Getting back to Mr Malkowski's question, what do I feel is the main difference with the MSA, what can the MSA do for seniors and care givers, is just that: prevent the frustrations on the health consultation line that we staff from 8:30 to 4:30. We get so many people calling—calling from New York City, calling from all over—very frustrated. We might be the seventh or eighth call. With all our advertising and outreaching, I wonder how it is in other municipalities. I know, just being a consumer, how difficult and frustrating it is to just know who to call. That's the main thing I see the MSA can really—

Mr Jim Wilson: In rural areas like mine, they just referred one to the MPP's office. So give them Mr Malkowski's phone number.

Ms Leet: Now, that's an idea.

Mr Jim Wilson: Just "Jim will do it" is what I hear.

Mrs O'Neill: I just wanted to make two points, if I may. I find this a very helpful booklet, and my own communities have similar booklets. I guess what I'm looking at—and I guess I want to go back to a comment Dr Basrur made—I'm confused, though, that an MSA is going to be able to be one phone number when there are at least 100 phone numbers in here. I still don't know whether you can foresee that possibility. I wonder if you see yourselves or see any one of these groups taking the lead in East York, or if you see that East York would have to go in with another geographical area in Metro Toronto, because we're talking about 15; you've got 100,000 people.

We've had two other groups from Metro Toronto in here today who have definitely got concerns and what I would consider some serious misunderstandings about this bill and expressed those today, one being from North York and one being from a part of eastern Toronto. Can you respond to that? Because, really, those of us who have worked on this and worked on Bill 101 still have difficulty feeling confident that we can accomplish in Bill 173 what is being proposed.

Dr Basrur: I'm just speaking in terms of personal opinion, because I don't think there is a right answer to your question. I can't speak in retrospect; I can only predict, which is a little dicey. And I'm not part of the basket, so I'm talking about someone else's bread and butter on top of it.

I think in terms of whether the 101 numbers could all be included under the MSA's roof, you're quite right; absolutely not. It might be that there would be a direct or indirect link between the basket of services and what we've listed in the booklet, but it might not make sense—it probably wouldn't make sense—for some of these to be included.

I think the approach we're taking in East York—I may be proved wrong, but I think this is what feels right to me—is that we're working with the things that clearly are within the basket as our starting point. So the Meals on Wheels programs, the home support, the home care and

visiting nurses and so on are clearly going to be within the basket and we're not worried about what's out on the margins at this point.

We're trying to sort out what the core of service will be, how it'll operate, how people will be assessed, how they'll flow through the system etc. How will the meals program operate if it's part of a larger umbrella? How would the transportation service operate? How does it operate now? How would it operate in the future? What's the give and take in making the transition? That type of thing, and doing it on a programmatic basis, doing it at a governance level. I am speaking into the future on some of this, because we're really still in the starting phases.

When it comes to the more peripheral areas; public health, for example, is part of a second tier of linked services. We're definitely not going to be in on the nitty gritty of planning and incorporation and so forth, but we will be involved in the planning. We sit at the planning table as members but when there are decisions that need to be made, they're more germane to a core group of people.

It might be that some of the agencies that are listed in here like—I don't know. Maybe there's a suicide prevention service of some kind. Those I think we might have to call on a case-by-case basis. I wouldn't want to predict which way any one of them would go, but likely we'll err on the side of certainty in terms of what ought to be in.

Mrs O'Neill: Thank you for trying to be helpful. The other is the dental problem of seniors. You may be interested to know that we're going to Hamilton on Thursday and the Ontario Dental Hygienists' Association is going to present in, I think, more detail than yourselves. This is a problem that's been brought to me. I happen to be the critic for seniors of the Liberal Party and it's been brought to my attention by several dentists and certainly by the organization of the dentists in Ontario.

I really didn't realize it was quite as difficult as you mention. If a doctor refers the case, can it be covered by OHIP? Is that the difference between the emergency—is it possible to get a hospital extraction, I guess is what I'm saying, in any case?

Dr Basrur: The information I obtained was from our dental hygienist and what she advised was that it's not possible. That doesn't preclude that a hospital might have its own unique arrangements or certain providers have worked out something. There are always going to be exceptions. But in our area, the experience has been as we've described it.

I would say that I really—I must speak only for East York. If you go to the city of Toronto, they have dental clinics funded 100% with local municipal dollars through their health department. We don't have that provision so we don't have anything. But there might be variations across the province that are similar.

Mrs O'Neill: So some of it is through the social assistance provisions of—certain cities have used this as an optional program in some cases.

Dr Basrur: Yeah. For example, in Metro if you're on

general welfare assistance, you have emergency dental care. But I believe that entitlement ends at age 65.

Mrs O'Neill: I see. Okay, I think this is something that is really important and I hope it will be included in the bill. You and others, I'm sure, are going to emphasize that, and it certainly is health care.

I think it's most important that you talk about how the complications then arise and also I think there have been mistaken identities by seniors in themselves that they're suffering from a dental problem and it's not a dental problem at all; it's something more serious.

Dr Basrur: Right.

The Vice-Chair: That completes the hearings of the committee for this evening, I understand. The Ontario Dental Hygienists' Association had a presentation handed out to you and I'm reminding you to take it to Hamilton with you. I don't know what will happen if you don't but that's the request. You may have to go without—without the presentation, I mean.

Thank you for your attendance. The committee is adjourned until 10 am tomorrow morning in the same location, with a new Chair.

The committee adjourned at 2149.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- ***Chair / Président:** Beer, Charles (York-Mackenzie L)
- ***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- *Carter, Jenny (Peterborough ND)
Cunningham, Dianne (London North/-Nord PC)
Hope, Randy R. (Chatham-Kent ND)
- *Martin, Tony (Sault Ste Marie ND)
- *McGuinty, Dalton (Ottawa South/-Sud L)
- *O'Connor, Larry (Durham-York ND)
- *O'Neill, Yvonne (Ottawa-Rideau L)
Owens, Stephen (Scarborough Centre ND)
- *Rizzo, Tony (Oakwood ND)
- *Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Also taking part / Autres participants et participantes:

Ministry of Health:

- Czucar, Gail, legal counsel, long-term care legislation
- Quirt, Geoff, acting executive director, long-term care division
- Wessenger, Paul, parliamentary assistant to the minister

Substitutions present / Membres remplaçants présents:

- Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham
- Malkowski, Gary (York East/-Est ND) for Mr Hope
- Sullivan, Barbara (Halton Centre L) for Mr Eddy and Mr Beer
- Wessenger, Paul (Simcoe Centre ND) for Mr Owens

Clerk / Greffier: Arnott, Doug

Staff / Personnel:

- Boucher, Joanne, research officer, Legislative Research Service
- Gardner, Dr Bob, assistant director, Legislative Research Service

CONTENTS

Tuesday 16 August 1994

Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,	
projet de loi 173, <i>M^{me} Grier</i>	S-1657
Ontario Home Health Care Providers' Association	S-1657
Steve Haas, president	
David Gooch, the past president	
Allayne Evans, second vice-president	
Ontario Coalition of Senior Citizens' Organizations	S-1662
Dan McNeil, co-chair	
Bea Levis, co-chair	
Dian Goldstein	S-1666
Senior Link	S-1670
Judith Leon, executive director	
Social Planning Council of Metropolitan Toronto	S-1674
Peter Clutterbuck, executive director	
Baycrest Centre for Geriatric Care	S-1680
Dr Moshe Greengarten, vice-president, public and community affairs	
Association of Allied Health Professionals	S-1683
Catherine Bowman, executive director	
Ontario Public Service Employees Union	S-1689
Bob Reid, executive board member	
Tracey Mussett, member, Local 477	
Saint Elizabeth Visiting Nurses Staff Association	S-1694
Laurie Clapperton, representative	
Ontario Palliative Care Association	S-1700
Shari Douglas, president	
Connie Smith, vice-president	
Victoria County Community Care	S-1703
Val Barkey, executive director	
Peggy Long, chair	
Senior People's Resources in North Toronto	S-1709
Bunny Segal, board chair	
Barb Coupal, chair, long-term care committee	
Bau St-Cyr, manager, home support	
Jane Moore, executive director	
Freda Finley, past president	
Charlotte Maher, board member	
Community Hospice Association of Ontario	S-1718
Heather Balfour, executive director	
Ontario Home Care Case Managers' Association	S-1721
Marg Kovacs, immediate past president	
Caroline Read, vice-president	
Margaret Chiles, president	
East York Health Unit	S-1726
Michael Prue, mayor, East York	
Dr Sheela Basrur, medical officer of health	
Pat Thomas, director, adult health	
Janice Leet, community health nurse	

S-60



S-60

ISSN 1180-3274

**Legislative Assembly
of Ontario**

Third Session, 35th Parliament

**Assemblée législative
de l'Ontario**

Troisième session, 35^e législature

**Official Report
of Debates
(Hansard)**

Wednesday 17 August 1994

**Journal
des débats
(Hansard)**

Mercredi 17 août 1994

**Standing committee on
social development**

Long-Term Care Act, 1994

**Comité permanent des
affaires sociales**

**Loi de 1994 sur les soins
de longue durée**



Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Wednesday 17 August 1994

Mercredi 17 août 1994

The committee met at 1004 in room 151.

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

ONTARIO COMMUNITY SUPPORT ASSOCIATION

The Acting Chair (Mr Dalton McGuinty): Good morning, ladies and gentlemen. Welcome to the continuing hearings on the matter of Bill 173, An Act respecting Long-Term Care.

Just to go over the ground rules for our presenters and for the benefit of or a reminder to our members sitting on the committee, each presenter is entitled to one half-hour for the presentation, including questions and answers thereto. Keeping that in mind, I'd ask you to begin, please, by first introducing yourselves.

Mr David Wartman: Good morning. My name is David Wartman, and I am president of the Ontario Community Support Association. With me this morning is Dan Stapleton, our executive director, and we will be presenting on behalf of the organization. Also joining us this morning are Mark Adler and Eunice McGowan, who are vice-presidents of the association.

I hope you'll bear with me. I seem to have reached that age where I can neither see with my glasses on or with them off, so I'm going to be stumbling a bit, I expect.

Our presentation will begin with a brief overview of who we are. This will be followed by the areas of the legislation OCSA endorses and our key areas of concern. Given the time constraints, we have submitted in writing a more thorough summary of our concerns for your consideration. Your packages include our presentation notes, our detailed response and our membership listing. The formal presentation will be approximately 20 minutes, followed by, I hope, 10 minutes for discussion and any questions you may have.

What is OCSA? The Ontario Community Support Association is an organization of direct providers of community-based services. Our primary purpose is to support, promote and represent the interests of community-based, not-for-profit health and social service agencies across Ontario.

OCSA was created on April 1, 1992, through an amalgamation of three provincial organizations which recognized that the combined skills, knowledge and experience of their services and resources would better serve all seniors and persons with a disability in the

province. These associations, Meals on Wheels of Ontario, the Ontario Association of Visiting Homemaker Services and the Ontario Home Support Association, have long recognized a common interest in supporting community services and have a long tradition of service in the community. In fact, 1993 marked the 30th anniversary of the Meals on Wheels program in Ontario.

OCSA is governed by a board of directors consisting of 25 community leaders from across the province, including representatives from the francophone and native communities. All are volunteers. Their combined experience of service provision at a grass-roots level guides the direction of OCSA.

In over 300 member agencies across the province, our organization provides community support services to the elderly, people with a disability and those convalescing from an illness to enable them to live safely and happily at home. Over 10,000 dedicated staff and an army of over 45,000 active, hands-on volunteers work diligently to provide a wide range of services. Many volunteers are seniors themselves. In 1993, these volunteers donated over 1.2 million hours of service.

The continuum of community support services provided by our member agencies across Ontario include the following: Meals on Wheels; homemaking; home maintenance; friendly visiting; Alzheimer day programs; congregate dining; foot care; client intervention and assistance and community outreach; home help; care giver relief; emergency response; transportation; seniors' day programs; information and referral; intergenerational programs; and telephone reassurance.

You have in your package this brochure. If there's any question about those services, the brochure actually defines the services.

Each year over 600,000 Ontario residents receive help from community support programs. OCSA works with governments, related associations, the general public and the private sector to develop innovative and responsive strategies to expand community support services and support the efforts of seniors and others with special needs to remain independent in their homes.

Our area structure: OCSA is subdivided into 15 areas which form the foundation of the association. It is through this area structure that members are able to have an equal voice in the association while allowing each area the flexibility to respond to needs identified by its own membership. Our area representatives will also be presenting to this committee at the regional hearing centres.

One of the great strengths of a provincial organization

like OCSA is the direct, concerted voice provided. OCSA works on behalf of seniors, disabled adults, member agencies and volunteers to ensure that issues which affect community services and seniors are heard and addressed by government policymakers.

OCSA has been an active participant in Redirection of Long-Term Care and Support Services in Ontario. We appreciate the opportunity to share our perspective on the legislation being examined and look forward to the continued partnership with government and other community organizations in the implementation of long-term care reform.

Our areas of endorsement include the following: The membership supports several aspects of Bill 173, An Act respecting Long-Term Care. The association endorses the principles and values enunciated in Bill 173. It has been these principles that have guided our response. We support not-for-profit service delivery where the principles of community-based planning, equity of access and equality of services prevail. We are committed to the development and implementation of standards of care and continual improvement in the level of service quality.

1010

Other specific comments are as follows.

Purposes of the act: The Long-Term Care Act sets out consistent criteria and accountability provisions governing service delivery designed to ensure accountability to the consumer, to government on behalf of consumers and to the general public. OCSA strongly supports the objectives contained in the purposes of the act. It is a key component of this legislation. In our written submission, of which you have been given copies, we have suggested some minor revisions to enhance the purposes outlined.

The bill of rights: We are committed to a service delivery mechanism that is driven by individual consumer needs, which responds to the requirements of natural communities and their cultural diversity and that will support the development of equity of services across the province. OCSA recognizes and endorses the client's bill of rights as outlined in the legislation. The necessity of the client being informed is an essential component to providing client-centred services. We have noted some concerns related to the expectations of agencies in implementing the appeal process in our written material.

Rules governing approved agencies: OCSA supports the alternative MSA models which endorse the principles outlined in the purposes of the act and which are a result of the community planning process. OCSA agrees that the functions of the approved agency will include the following: to provide information and referral regarding long-term care and support services; to offer a range of long-term care and support services; to integrate the functions of assessment and service delivery; to determine the eligibility for services; and to develop a plan of service for eligible persons with a review and revision of the plan when necessary.

Linkages with other social services and health providers are essential. Mutual respect among key stakeholders in the long-term care service delivery system will facilitate and encourage linkages among community

service agencies with physicians, pharmacists and other health and social service professionals and community organizations.

The act must ensure that services are planned, delivered and evaluated from an integrated health and social service perspective. We believe in a long-term care system that stresses the importance of maintaining and promoting health, wellness, and early intervention in addressing client needs and that provides flexible service along a continuum of care.

Proposed changes to the Public Vehicles Act: Changes to the Public Vehicles Act will allow a service provider to operate for the purposes of transporting persons determined eligible by an approved agency. OCSA applauds the government for including this provision in Bill 173.

I would like to now turn it over to Dan Stapleton.

Mr Dan Stapleton: I'm going to concentrate on the areas of concern. I should say by way of preface that we conducted a consultation with our membership, and our membership consists of over 350 members, of which over 300 are agencies providing community support services. Based on the input from our member agencies, we'd like to present six key areas of concern with this legislation. The detailed response you've been given includes a number of other concerns, but the six we're presenting were those that were considered by the board and the policy committee of our association as being the most pressing, and they include the following: areas not covered in the legislation; the regulations; volunteerism in the reformed long-term care system; multiservice agencies; categories of services; and definitions. With each area of concern we will present the issues and then suggest recommended strategies for improving the legislation.

First is areas not covered by the legislation.

In the document Partnerships in Long-Term Care: Guidelines for the Establishment of Multi-Service Agencies, released in September 1993, messages regarding the perceived preferential treatment of unionized employees in the new MSA became apparent. Subsequently, in Bill 173, there were no references regarding the protection of not-for-profit community-based employees as a result of the implementation of long-term care reform.

Long-term care reform acknowledges the need for experienced, trained staff for the provision of services, yet the proposed process for development of multiservice agencies, along with social contract reductions and constrained finances, all currently have or will potentially have a negative impact on employment in the broader socio-health care sector.

Although there are similarities between clients in institutional settings and those in the community, the environments are quite different. Therefore, special consideration is required when transferring staff from facilities to community-based agencies. For example, there are differences in the skill sets and the goals of care or methods of achieving goals. Training resources are required not only for employees who are laid off but also to encourage existing employees to enhance their skill

base. A forgotten group of employees who work through brokerage agencies should have their experience recognized in this process.

The community support sector consists of over 10,000 employees who are experienced and trained in the care and delivery of services. These staff have worked for years at low wages and minimal benefits with a strong commitment and loyalty to providing quality services. Unionized employees in the broader socio-health care sector are demanding priority employment in the community sector. Our sector is predominately non-unionized and is thus less able to voice concerns than organized labour bodies.

OCSA strongly believes there needs to be a commitment to fair wages and benefits for employees, and there is also a need to ensure maximum expenditure on direct care service.

There will be significant human resource issues which will require expertise, time and financial resources in order to be addressed successfully.

Our association recommends that client continuity and respect for the relationships between existing employees and consumers of service should be paramount. Consequently, employee transfers to new agencies should be seamless, with no break in employment or client service.

All employees of not-for-profit community support service agencies should be guaranteed comparable positions in the new service delivery structures without loss of seniority. Otherwise, in all community support sector hiring, displaced employees from not-for-profit community support service agencies should be given priority over other socio-health sector employees.

Our second concern has to do with the general regulations.

It is our view that Bill 173 has taken an overly prescriptive approach to the provision of community-based services: 42 regulations have yet to be produced. Much is unknown at this point, yet the areas to be covered appear to be quite prescriptive. It is difficult to present a response to the legislation in the absence of the detailed information which will be in the regulations.

Bill 173 allows for the provision of regulations to be retroactive. However, MSAs will be developed over a period of four years. Consequently, it will not be feasible in certain instances to make the regulations retroactive.

The province is moving quickly to put multiservice agencies into practice, yet major components need to be put into place, for example, eligibility criteria, program standards, MSA guidelines and the regulations.

OCSA feels, therefore, that we must be actively involved in producing and approving the regulations to be developed for Bill 173. Furthermore, we recommend that extreme caution needs to be applied in setting retroactive dates of application.

Our third concern deals with volunteerism in the reformed long-term care system.

Volunteerism is an essential component in the delivery of community-based services. The volunteer base must be recognized as being deeply rooted in the community and

potentially fragile, yet there is only one regulation which requires an MSA to develop and implement a plan for recruiting and using the services of volunteers.

In addition to their valuable work in service provision, a significant amount of money is made available for services as a direct result of the fund-raising efforts of volunteers. If volunteers are not properly maintained, costs will skyrocket. Thus, MSAs will not be cost-efficient and the ability to meet existing consumer needs will be jeopardized.

There is a lack of detailed planning regarding volunteers and long-term care, even though there is a concern about an inadequate number of volunteers currently to support the expansion of programs and services. Historically, volunteers have been the backbone of community support services and they must be recognized and the issue addressed. The relationships presently existing between service agencies and their volunteers must be fostered and nurtured through the transitional process. Volunteers should be kept well informed and actively participate in the change process in the implementation of long-term care reform. Furthermore, sufficient resources to support a volunteer management structure at the natural community level should be provided on an ongoing basis.

OCSA therefore recommends that there be a recognition of the role of volunteers in the body of the legislation.

We also recommend that volunteer management in regulation 11 should be expanded to require MSAs to develop and implement a plan for the recruitment, training, scheduling, supervision, retention, recognition and expense reimbursement of volunteers.

1020

Volunteers are motivated by an array of factors and cannot be shifted organizationally away from their work without risk of loss, and therefore it is absolutely vital to maintain the linkages between volunteer tasks, their communities and the agency staff that sustain them.

Our fourth concern deals with multiservice agencies.

It is essential that there be sufficient flexibility to allow communities to develop an MSA system to meet local needs. It is unclear what the final MSA model will look like in each community until the community planning process is over. Consequently, it is premature to assume that the same model will meet the needs of all residents in Ontario.

One-stop or single access does not necessarily mean that all services and care providers have to be assembled under one roof and that consumers have only one point of contact in a community. It may, for example, be achieved by a functional integration of information, referral, assessment, case management, service delivery and follow-up in multiple locations.

On the other hand, we must ensure the client does not become discouraged by being continuously referred to various services, as is currently the practice. The act also lacks recognition of the existing multiservice agencies which provide services in addition to long-term care services.

OCSA supports different models for MSAs which endorse the principles outlined in the act and which are a result of the community planning process. We believe that MSAs must not be allowed to develop into large, bureaucratic organizations. They must be small enough to be able to be responsive to local community needs.

We also believe that there must be consistent standards developed, or the unacceptable status quo will be maintained.

Improved coordination and access to available services are highly desirable. Close coordination will be needed if there is more than one point of contact in the community. Communication among providers is key.

Functional integration of information could be achieved through electronic communications systems and/or by combining physical locations for smaller community support agencies to achieve economy of finances and volunteers.

We recommend that if functional integration is pursued, top priority must be given to ensuring that there is an effective computerized information network in place. This must include a financial commitment to design hardware, software, training and support.

Our next concern deals with categories of services.

The separation or distinction between community support services, homemaking, personal support services and professional services reinforces a hierarchy of services ultimately geared to medical needs, rather than fostering a continuum of care. It reinforces a split between health and social services and moves away from wellness, health maintenance and prevention measures. This is inconsistent with the purposes of the act, and it will be confusing to the client and the case manager who will be pressured to approve the need for personal care.

The distinction between personal support services and homemaking services appears to be contrary to the current trend to develop a "generic" worker, which would combine health care aides, homemakers, home support workers, home helpers and attendant care workers. In most agencies, both personal support services and homemaking, as defined in the act, are provided by the same person. These services are provided concurrently, and this worker will be the recipient of a recently developed training program. The inclusion of these two services separately in the legislation we feel is a major step backwards and could interfere with the development of a generic worker.

There are also some concerns about how these two services will be operationalized. This separation will be an administrative nightmare for the service provider or approved agency. For example, how does the service provider manage the client who requires a bath—that's personal support services—and laundry, shopping and housecleaning, which is homemaking? Both services are important in terms of maintaining the client's independence in the home. Will the time be prorated?

New terminology is being used and initially this may cause some confusion in the community. Personal support services, for example, was previously known as homemaking. "Homemaking" is being used to describe tasks

previously referred to as home help. However, it is recognized that the terminology currently being used varies considerably across the province, and there is a need to have standardized definitions.

We question the use of the four categories: community support services, homemaking, personal support services and professional services. It is more important for each community to have a menu of services which they can tailor to meet their needs. Service priorities must be established through a local planning process and not directed from a top-down approach. This is one of the planning responsibilities of district health councils, which are working in partnership with consumers and service providers. A definition of services to be provided by MSAs must allow for flexibility to encourage the development of innovative programs which can more effectively and efficiently be developed through a community development process.

We recommend that the artificial distinction between homemaking and personal support services be ended by combining them, and we would like to be involved in the development of a new term to describe this service.

There is too high a level of detail in the legislation that we feel will result in rigidity rather than flexibility to meet local needs. Perhaps through standards development and program guidelines these areas can be addressed.

We recommend that community support services, homemaking, personal support services and professional services be combined into one category. Thus, there would be a range of community-based services available. Based on this recommendation, subsection 2(3) would be deleted, subsections (5) and (6) would be combined and listed as one service and all services would be listed in alphabetical order, including services listed in subsections (4) and (7). This proposed change would also affect subsection 1(12). This recommendation minimizes the artificial distinction currently being made between community support services, homemaking and personal support services.

We also feel that the user fee issue should remain separate and not be included in the legislation.

Assuming the legislation is passed and regulations are introduced, a communication plan to educate consumers and service providers on the changes is needed. It will initially be more confusing, especially for the consumer.

Our last concern has to do with definitions.

This legislation is seriously deficient with regard to both its consistent use of some definitions and the absence of other definitions. Definitions, for example, are provided for adult day programs, care giver support services, meal services and transportation services. However, definitions are not provided for other services and terms, such as respite care services, social or recreational services, security checks and reassurance services, friendly visiting, home maintenance and repair, service provider, program supervisor and director. There is extensive detail provided for homemaking and personal support services, yet professional services are merely listed and not defined. "Assistance" under care giver support services is undefined. This is quite open-ended.

For example, does this mean that agencies will provide meals, transportation and home maintenance to care givers? Will eligibility criteria for care giver support services be set by the MSA or by the province?

The main issue, we feel, is, what is the most appropriate avenue for service definitions? We believe that OCSA must be involved in the development of definitions of services to be provided, as these services are provided by our members.

I'll just turn the floor back to David for our conclusion.

Mr Wartman: OCSA applauds the leadership demonstrated by the provincial government through the development of Bill 173, which establishes a key building block in the foundation of the new long-term care system. We appreciate the commitment to building partnerships with the community to effectively plan and implement meaningful change. We look forward to working in continued partnership with the government and our community colleagues to bring about the redirection of the long-term care system.

1030

Mr Jim Wilson (Simcoe West): Thank you for your presentation. As you know, yesterday Mr Quirt made it quite clear that your group was primary—paramount, I should say—in influencing the government to move towards an MSA model, particularly a model that not only has one-stop shopping, as it were, in terms of how I initially understood the concept, and that was that in geographic areas there'd be one phone number to call, a fairly simplified version of what we see in this legislation, but also that MSAs should deliver the services.

You've mentioned some concerns. The ones that are repeatedly offered to this committee are ones you've touched on, for instance, the role of volunteers, the retainment and recruitment of volunteers and the effect that fund-raising might have. I put to you that no amount of legislation or regulations will ensure that volunteers continue to be attracted to work for these agencies if people believe they're working for an MSA, which, regardless of whether it's a non-profit charitable organization or whatever, I can tell you, because program supervisors and many of the appointments are made by the crown, the public will see as government organizations. Do you have any further comments on how we continue to make sure some of the member agencies retain their identity, because I can tell you, when we amalgamate municipalities and other things the government has been infamous for amalgamating over the years, they do lose their identity after a few years.

Mr Mark Adler: If I could respond, sir, I'd like to say two things. One will have to do with the public perception of who the new service organization is. Looking at the planning process and as a participant at the community level in the planning process, where, for example, in the city of York, where I work, we have two home support and Meals on Wheels agencies participating, Saint Elizabeth nursing, Victorian Order of Nurses, the home care program, public health departments, a community health clinic, as well as a variety of service provider volunteers and consumers on what amounts to a

planning consortium which will lay the framework for the new organization, I don't believe, given that high level of public and agency input into the creation of the new organization, that the local community will see these organizations as being government-driven, and in fact there are no government providers at the table, or bureaucrats, in terms of planning and creating these new structures.

Secondly, as a director of an agency that provides a variety of seniors' services, I think I would dispute the contention that people in the community volunteer based upon a knowledge of the history and the philosophy guiding an organization, but rather they are more interested in the direct provision of services. When my agency puts out a call for Meals on Wheels drivers, the community responds, because people see Meals on Wheels as a valuable community support, as a sign of being a good neighbour, and they seek out the opportunity to provide the service for whoever the provider organization may be.

That being said, I think we need to recognize that this is a system that needs resources, and as we stated in our overview, volunteers will not come into the system on their own, they can't be retained by the system on their own, there needs to be resources for effective volunteer human resources management. Volunteers can be cheap, they can be cost-effective and they can provide quality to a system, but there needs to be a system in place to support them.

In the current system now in Metro Toronto, where, for example, there are 80 agencies as opposed to the proposed 20 agencies providing these services, government will be very challenged, and has been, to provide effective resources for those agencies to do volunteer management, recruitment, training, recognition, retention and all those issues. It's our hope that by condensing the system down to manageable size but not excessively sized organizations, those volunteer human resource issues can be dealt with more effectively.

The Acting-Chair: We have time for one more brief question.

Mr Paul Wessenger (Simcoe Centre): Thank you very much for your brief. I'd just like to assure you, with respect to the staffing structure, that will be flexible. We appreciate your comments on that, and although the services may be distinct, there's no reason why one individual can't provide more than one of those types of services.

The question I have to ask is, you indicated you had some concern about the negative impact of employment with respect to the restructuring and in view of the fact that there are increased moneys going into long-term care, increased employment opportunities, approximately 5,000 jobs being created, and the fact that the responsibility for developing fair treatment of employees is at the local level, at the new MSA, in developing a human resources plan that is fair. Certainly I agree with the principles you suggest with respect to how employees should be treated. I'm wondering why you would feel in those circumstances that there would be, or might be, a negative employment impact.

Mr Stapleton: I think our concern is that although

dollars have been allocated for long-term care reform, the new structure and the one-stop access will actually create more need because the services will be better known. I think our feeling is that there isn't going to be enough money to provide all the services and that something will have to give and that there will not be enough money to actually manage all those services and keep staff employed.

The other concern is that although there's been talk about new jobs, they're primarily direct service jobs. We have a number of employees who work in administrative functions and it's very unclear whether or not there would be a continued role for them in the new system. Every person who's currently an executive director can't continue in that role, so what we would like to see is guaranteed comparable positions in the new organization and that's something we have currently not felt has been given any assurance to date.

ST CHRISTOPHER HOUSE

The Acting Chair: Our next presentation will be made by representatives of St Christopher House. Please take a seat, and before beginning, kindly introduce yourselves.

Ms Lucia Furguele: My name is Lucia Furguele. I'm the director of the Older Adult Centre at St Christopher House.

Ms Dorothy Myles: And I'm Dorothy Myles. I'm president of the members' council of the Older Adult Centre.

Ms Furguele: I think we can begin. First of all, I'd like to thank the standing committee on social development for the opportunity to express our response to Bill 173, An Act respecting Long-Term Care. Dorothy and I will be sharing the presentation, and I would just like to say that our presentation is representative of a community-based organization and presents our views as well as our consumers' and care givers', with whom we have conducted a number of consultations.

St Christopher House is a neighbourhood-based multiservice organization located in the west-end communities of Toronto. St Christopher House has at its central purpose the enabling of less advantaged individuals, families and groups in the community to gain greater control of their lives and their community. We work with people of all ages and circumstances: youth, newcomers and immigrants, women, persons with disabilities and the elderly. Our services include after-4 programs for kids, women abuse counselling, literacy and English as a second language, a drop-in for street people and housing-disadvantaged persons, employment training, counselling and placement for youth and young adults and some community economic development programs for unemployed members of our community. At our main House location on Dundas and Ossington, we have an Older Adult Centre serving over 2,000 seniors, families, care givers and persons with disabilities. St Chris is a focal point where community members of all ages, abilities, income levels and cultural backgrounds come to meet.

Ms Myles: I'm new to this game, and as a senior, I'm

a little nervous, of course, in the presence of such honoured company. I made a tour just recently with my granddaughter of the Legislature chambers and everything, so I'm not completely unfamiliar with the building.

The Older Adult Centre, of course, is predominantly in a Portuguese and, increasingly now, Vietnamese and Chinese area. We provide a number of community support services, including Meals on Wheels, transportation, home help and client intervention and assistance, which is a counselling and case management program. There's also an Alzheimer day program, an elderly persons' centre, which I am part of, for recreational, wellness and health promotion activities and a newly acquired contract with Home Care for an integrated homemaker program. In addition, we have a strong outreach and community development component to all of our programs.

Our consumers and participants have taken leadership in the planning and directing of activities and committees, and further leadership development has been identified by our members' council as a priority for the coming year.

1040

St Christopher House participation in consultations regarding long-term care is high. Over 200 of our members and consumers were interviewed in their homes or at St Christopher House regarding their concerns and ideas. Members of the Older Adult Centre have joined forces with seniors from across Metro to address health care issues and have named their coalition In the Picture. You may have heard quite a bit about that. They've been in the news and they have so many meetings. They have had meetings with Ruth Grier and the federal Minister of Health.

The Older Adult Centre also helped with three large community forums: one with the Portuguese interagency network, one with the Chinese interagency network and a community health forum for our larger community. Our seniors have also met a few times with Elaine Ziemba to express their concerns about long-term care. All of our community focus groups and forums have been provided in three or four languages and with assistive hearing devices.

In addition, our executive director has participated in the Ministry of Health and district health council's hospital realignment committee and the mental health reform committee.

Ms Furguele: Right, and I sit on the district health council's long-term care reform steering committee.

Ms Myles: The Older Adult Centre staff and consumers are also participating on MSA design groups in the downtown and the west-end consortia.

We welcome the opportunity to continue to provide input and feedback from consumers who have traditionally been unable to participate. We support the vision and philosophy of long-term reform.

We have six concerns we wish to discuss today, related primarily to consumer and care giver issues and the eroding of the community sector approach and the philosophy of working with neighbourhoods. I'll just do run a rundown. They are: consumer focus, care-giving

issues, community outreach, community development, community voice and the basket of services. Now, many of these are perhaps incorporated in some of the other submissions you will have received. Of course, I'm not cognizant of those, so you may find some repetition.

Consumer focus: This government is to be congratulated that it has spent so much time and effort to consult with consumers on various aspects of the long-term care service delivery. We understand that over 70,000 elders, persons with disabilities, care givers and volunteers have participated in a process which strongly emphasizes the importance and commitment to consumer-driven reforms.

St Christopher House also consulted over 1,000 consumers through focus groups with our own members and with Chinese and Portuguese interagency networks.

We are disappointed that in light of this level of citizen participation, Bill 173 fails to position the consumer at the heart of four key aspects of the legislation.

Governance: The legislation does not specify that consumers and care givers must be designated a certain number of seats on MSA governing bodies. Our own participants and Metro-wide seniors' and consumers' coalitions have been strong about their position related to governance. Our organization strongly endorses many consumer groups' recommendations of 50% consumer/care giver designation on MSA boards of directors. This will ensure that their voices will be heard in the planning and development of programs. Local MSA design consortia are strongly in favour of this designation. Our recommendation is that the legislation make specific reference to consumers having a designated number of seats on governing boards. This is an important issue for us.

The appeal panel: While the function and responsibilities of the appeal panel are clearly defined, we recommend that consumer care givers be given a specific designation to the appeal panel. That is to allow more participation with the consumers and care givers with the recommendations from the appeal panel.

Ms Furguele: Bill 173 makes a specific reference to ensuring that all persons will be served by MSAs regardless of income, religious affiliation or ethnoracial background. Nowhere in the legislation does specific reference to the Ministry of Health's anti-racism strategies appear in relation to MSA mission and governance or functions. These strategies address the present systemic discriminations and barriers to service that both employees and potential clients experience.

In order to ensure access for persons from ethnocultural and racial backgrounds, policies and guidelines outlining employment equity policies, fair and accessible recruitment and selection of staff, opportunity for advancement, means for organizational evaluations and other organizational systems must be firmly in place. MSAs must recruit staff and volunteers who possess language and cultural sensitivity and a demonstrated commitment to outreach and connection with the communities served.

Much has been documented and voiced about the difficulty of accessing services if you don't speak English

or can't read or write. Achieving access must be approached in deliberate and committed ways: policies, governance structures, multilingual program and service capabilities, outreach and community development. These strategies are already mandated by this government and should accordingly be reflected in this legislation.

Ms Myles: The ombudsperson: The consumer safeguards described in the legislation related to a bill of rights and other appeal procedures are important measures. There is no doubt, however, that consumers have and will continue to fall between the cracks and require more than the stated provisions.

When all appeal processes are exhausted, it is recommended that a final process conducted by an impartial, objective and separate third party be available, such as an ombudsperson or advocate.

Now, under the care giver issues, much of the long-term care reform will be shouldered by care givers and volunteers. The documents published by the Ministry of Health pertaining to the guidelines and principles of long-term care reform made specific references to the needs of overburdened care givers.

Bill 173 makes reference to care giver support by describing what services comprise this support, including counselling, training, visiting and providing information and respite and other assistance to care givers to support them in carrying out their care-giving responsibilities. We strongly support any legislation that recognizes the enormous contribution care givers make to the health care system.

Care givers have voiced their need for (1) information on available services, (2) in-home and facility-based respite and (3) alternative financial assistance to help care givers, predominately women, face the financial challenge of looking after a chronically ill person at home.

Primary care givers, usually women, work around the clock to provide care. They need respite in order to maintain their own health and wellbeing. We have heard that some consumer groups have suggested using special hospital wings that have been closed for the respite care programs. Others prefer respite in the home.

The word "respite" threw me at first, until I realized I have my own sister-in-law, who looked after my brother. She got so browned off sometimes I used to go up and just sit and talk with her, and this is what is needed in many cases.

In any of these choices, families should not have to pay for this service. Respite care allows chronically ill persons to avoid institutions and for care givers to avoid burnout and exhaustion.

1050

Ms Furguele: Community outreach, or someone has called this "looking under bushes": Someone remarked recently that she found it unbelievable that community agencies would spend so much time on outreach activities. She referred to outreach as "looking under bushes" for clients and expressed disapproval, stating that if eligibility criteria are clear and programs well managed, clients will have no difficulty hearing about or accessing services.

At St Chris, and for most community agencies, looking under bushes has become an important means of ensuring that citizens know about and utilize services. We know that bushes for some people can mean English-language barriers, illiteracy, isolation, frailty or disability, poverty or abuse. These barriers prevent persons from ever knowing about services, let alone accessing them.

The act makes an assumption that a consumer will access services provided by the MSAs simply by meeting eligibility criteria. There is no mention of the need for outreach, development and information that likely will be required for many consumers and care givers within newly established MSA geographic areas. Bill 173 puts the responsibility on the consumer to somehow know about available services, rather than on the MSA to ensure that information is provided in languages and means that are appropriate to neighbourhood demographics. Consumers have stated that they are confused by the present long-term care system and not clear about how to access services. Outreach and information, health promotion activities and health education must be mandated as necessary functions of each MSA.

There has been much activity and cooperation among agencies as communities begin transitional planning for MSAs. The district health council has indicated that these MSA-designed consortia must demonstrate a commitment to including all stakeholders, including consumers, persons from ethnoracial communities, care givers and other special-interest groups.

The planning of MSAs is no doubt an important place for community development strategies to be utilized. But community assessment and community development must be stated as important, ongoing, essential functions of the MSA. This will be the only way to ensure ongoing organizational flexibility, community responsiveness and appropriateness of programs. It is not mentioned now and usually only interpreted as something that ought to be done in formulation stages only. Without community development being stated as a legitimate and imperative MSA organizational approach, it will be resisted and misunderstood. The last thing we want to create are more institutions that have no connection and understanding of their geographic neighbourhoods, their consumers or needs.

The community sector must be given equal visibility and voice in the reforming of the long-term care system. The legislation makes reference to health and social service sectors playing important roles in the development of MSA and service delivery, but the community sector, which has been able to respond quickly and innovatively to neighbourhood needs, is left out of the discussion.

An example of the discrepancy is the fact that there is no legislation to protect community sector workers, as there has been for health sector workers.

St Christopher House, like many existing multiservice organizations, reflects the vision of the health goals for Ontario, and efforts need to be taken now and in the future to sustain and strengthen this model. We are truly integrated in serving the vast range of ages, stages, backgrounds and needs in a community in a way that meets health needs in the broadest sense. Seniors, like

most of us, do not want to be ghettoized and compartmentalized. Access points in storefronts, using existing neighbourhood organizations, building on the strength of the system is what is required.

Community models have developed integrated approaches, innovative and sensitive outreach strategies, participatory program planning and delivery and responsiveness to community needs. We fear this philosophy of working will be eroded. We fear that the basket of services that are designated community support services will risk being cut in favour of more medically oriented ones. Already there is a proposed hierarchy of services, that is, some that are designated free and some that will cost, yet homemaking or Meals on Wheels may be just as vital as a visit from a social worker or a physiotherapist. We need to work at preventing the development of another bureaucracy with rigid eligibility criteria and anonymous workers who know little about their catchment area and the needs of their consumers.

We are especially worried about consumers who have been marginalized and who we have helped access services: people who do not speak English, people who are isolated, people who can't read or write or who are frail. These are consumers and care givers who will not be able to telephone an MSA directly, because they likely won't even know that one exists.

Ms Myles: Now I'll take over again. Client intervention and assistance, which we place under "Basket of Services": Client intervention and assistance is not mentioned in any document related to long-term care, nor is it mentioned in the legislation. Client intervention and assistance is a counselling and case management function developed by community sector agencies. It includes intake, assessment, supportive counselling, information and referral, advocacy, housing and placement coordination and crisis intervention. Client intervention and assistance workers are typically multilingual, sensitive to the needs of ethnoracial communities and skilled in outreach and community development.

It is recommended that CIA, client intervention and assistance, be specifically included in the list of the basket of services.

Elder abuse: Elder abuse occurs in many ways. It can be physical, emotional or financial. Though not easily talked about, many seniors experience violence or abuse in their home and community. Programs and legislation which will address the incidence, identification and prevention of abuse must be developed, and it is recommended that such programs be established as a mandatory service of each MSA.

Fee for service: We are concerned that some services will be free and others not. No one should be denied service because of inability to pay, and the legislation should make this a philosophical underpinning of each MSA.

Ms Furguele: That concludes our presentation.

Mrs Yvonne O'Neill (Ottawa-Rideau): I want to first of all congratulate you for the level of input you've had to this point in this whole process in every possible way you could, and particularly the way you've involved

the people you serve in that consultation.

I find that you've brought forward something that many have brought forward, in particular in your last statements, on the client intervention and assistance. I do think that will have to be included in the act in some shape and form.

I'm going to ask a question springing from some of your remarks to the parliamentary assistant, and it has to do with the eligibility criteria. I think you've brought forward that the onus is on the consumer, and you find that difficult, as do many other of the presenters and I myself. I'd like to know from the parliamentary assistant, who is going to determine the eligibility criteria? Is it the ministry or the regional offices or whatever way you're going to deal with that or the individual MSA, and how is the knowledge of the eligibility criteria proposed to be given to the community?

These are fundamental questions, almost every presenter brings them, and I would like to have an answer, and I really think that some of the answers yesterday were less than clear and in some cases almost flippant. I think we must deal with that.

Mr Wessenger: I will ask Mr Quirt to deal with those questions.

Mr Geoff Quirt: There will be eligibility criteria that will apply across the province in each MSA for the services listed in the bill. Those eligibility criteria have existed with the home care program. We're looking at those and modifying those to try to make them more sensitive to consumer needs and we're being helped in that regard by a number of advisory committees looking at—

Ms Myles: I can't hear.

Ms Furgiele: We can't hear.

Mr Jim Wilson: Mr Quirt, the witnesses indicate that they can't hear you.

Mr Quirt: I'm sorry, I thought I was speaking directly enough into the microphone. Let me start again and repeat what I said earlier.

There will be eligibility criteria that will be developed that will apply to services delivered by MSAs, in the same way that there are eligibility criteria now for the home care program and other services. We want to develop those eligibility criteria with the help of service providers and consumers, and as a result we have program design activities under way getting input from people about how to best measure eligibility. We talked yesterday a bit about how best to assess people and there's an ongoing discussion whether a consistent assessment approach or a consistent assessment form might be advisable. There's a lively debate on that that we hope will result in a good conclusion.

1100

As was suggested by a couple of the committee members yesterday, we'd be pleased to make a presentation to the committee of the work to date on eligibility criteria for the various services, get your input on that, and at the same time run through a legal presentation on the bill itself and its structure.

We would welcome input from the presenters on the eligibility criteria. I'm not sure if you were involved in our program design activities, but I know other adult centres have been consulted in that regard so there will be consistent eligibility criteria across the province. There will no doubt be some variability in the application of those criteria, sensitive to consumer needs at the local MSA level.

Mr Jim Wilson: Thank you very much for your presentation. I very quickly wanted to ask you about one of the terms that's used. I understand your points about outreach and the need to continually be looking under the bushes, as you mentioned in your written submission, and I understand community assessment. Can you tell me what you mean on page 9 by community development? You do recommend that it should be an important, ongoing function of the MSA.

Ms Furgiele: I'd like to answer that. One of our more serious concerns is around the size and function of the MSAs. We're a small, neighbourhood-based organization. We are mandated to represent the communities that we serve. So who the communities are is what St Christopher House is about. Through the years, with different waves of immigration and different neighbourhoods forming and settling in the west end of Toronto, we've been able to respond to those needs by policies and recruitment of staff and developing programs that are sensitive to the needs of those communities.

We think that the larger the organization, the more chance there is of losing that commitment and that connection with your communities, and community development to us means involvement of consumers and participants in all aspects of the organization. It's an empowerment model, it's an information model, it's an informed model that really allows for participatory involvement in all aspects of the organization.

Ms Jenny Carter (Peterborough): I'd like to congratulate you on your presentation, and I think it's very clear that your concerns are the same as ours. In other words, what we are trying to achieve with this bill is what you are wanting us to achieve, and the question is, are there any gaps there that we can make good?

There certainly is a consumer focus. That is what we're trying to do, and I think maybe there are a few more factors that should come into this picture.

For example, we do have the Advocacy Act, which is coming into force quite soon. You have a problem with people getting access to services, and I think it's going to be about as simple as it possibly could be. That is to say there is going to be one number to call for the multi-service agency and, for crisis, there's going to be one number to call for advocacy, so the question is to get those numbers into people's consciousness. Certainly the advocacy number will be displayed and a third person can call if they feel that somebody else is in jeopardy, and they can even remain anonymous. So I think we have looked after that.

Also, of course, we do have employment equity kicking in this fall, which means that all employers have to make sure their employees reflect the community, so I think that has been taken care of in that way.

You also mention respite care, and the institutional side of that I think was looked at in our Bill 101. Institutions do have to keep a certain number of rooms available for short-stay occupancy so that they will be able to accommodate people for respite care.

One thing you have emphasized is the question of consumers being represented, and I think there is some commitment to having at least a third of consumers on, for example, the long-term care subcommittees, but I think where we may be a little lacking is in our definition of consumers. For example, somebody who maybe is a retired care provider might come in under that category and perhaps not have the point of view that you feel is needed. So I wondered if you could elaborate on that.

Ms Furgiele: On the part about consumer participation?

Ms Carter: Who should count as a consumer and what the definition might be for representation.

Ms Furgiele: When we were doing our consultations with our members, it was a daunting challenge because most of our participants do not speak English, can't read or write, as I stated earlier, and many of them are home-bound seniors. We try to devise means of actually getting their voices involved in the consultation and it meant one-on-one interviews in appropriate languages, utilizing family members and so on.

So for us, consumers can be the actual recipient of the program. It can be a care giver. It can be someone who has used services in the past and so on. We support that general definition of consumer.

The Acting Chair: I'm sorry, our time has expired. I want to thank you both for taking the time and making the effort to come down here and speak to us and share with us some of your experience as people on the front lines.

ONTARIO PHYSIOTHERAPY ASSOCIATION

The Acting Chair: Our next presenters: representatives of the Ontario Physiotherapy Association. I understand that members of the committee were provided with a copy of the written brief yesterday. In the event that you do not have that brief with you, the clerk is now handing out another copy. I'd ask you to kindly identify yourselves and then begin with your presentation.

Ms Jennifer Cummings: Good morning. Thank you, Mr Chairman, and thanks to the committee for the opportunity to appear before you this morning. My name is Jennifer Cummings and I'm the president of the Ontario Physiotherapy Association. I'm also a physiotherapist working for the Grey-Bruce home care program. With me is Cathy Hecimovich. Cathy is also a licensed physiotherapist practising in home care.

The Ontario Physiotherapy Association has appeared before this committee several times over the past year on a range of issues. I suspect, therefore, that you know who we are and what we do and don't require a detailed background on our profession.

Just briefly, however, there are 5,000 licensed physiotherapists in Ontario. We are regulated by the college of physiotherapy under the Regulated Health Professions Act and the Physiotherapy Act of 1991.

The Ontario Physiotherapy Association represents over 3,000 of these physiotherapists. One can find physiotherapists and access physiotherapy care in a range of venues, in hospitals and hospital outpatient clinics, in OHIP-funded clinics, in private clinics, in private industry, in sports and fitness clinics and rehabilitation centres, in nursing homes and seniors' residences and, of course, at home through any one of the 38 home care programs provided and operated by the province.

I want to emphasize that we have the statutory authority and the expertise to assess physical dysfunction and to treat, rehabilitate and prevent physical dysfunction, injury or pain. When we encounter the need for treatment beyond our expertise or scope of practice, we refer the patient to the appropriate profession. Neither we nor long-term care require that a physician or any other health care profession supervise our activities or position themselves as gatekeepers into the system or to the physiotherapy services that it provides.

I'm now going to turn our presentation over to Cathy Hecimovich, who will speak to the current issues facing physiotherapists working in home care today.

Ms Cathy Hecimovich: Hello. I've worked in home care now for 10 years. Home care, which is the subset of long-term care, is like nothing else in the health care delivery system. Home care practitioners treat a patient base that is culturally, socially, economically and medically unique in its diversity. We see the undisguised patient, the patient in his or her own environment, who often presents very differently than does the same patient in a hospital context.

In home care, we see their real isolation. We see how well or how poorly their support system works. We see their lack of financial resources. We see cases of neglect and abuse as the family support system breaks down with the stress of continued care for a disabled person. We are often the only outside people who see these people and visit them regularly in their homes.

1110

Physiotherapists working in community-based care treat patients in homes, schools, seniors' residences and nursing homes.

The types of patients we see range from people on ventilators, palliative clients with AIDS or cancer, to people with long-term neurological conditions such as stroke, Parkinson's, MS or patients with orthopaedic conditions such as arthritis, joint replacements, and other frail elderly who are at risk from falls, pneumonia or other debilities of aging.

Of the approximately 1,400 physiotherapists working with long-term care clients in one setting or another, approximately 550 work through existing home care programs. These physiotherapists provide just over half of all home care therapy services, which include speech, dietetics, social work and occupational therapy.

We work alone. Our car is our mobile office, clinic and storage area.

We travel everywhere, in foul weather or fair, in daytime or at night, in rural or urban areas, in unsavoury neighbourhoods. Health and safety regulations that protect

the employee in workplaces are often unenforced in residences that we visit. We face unhygienic, unsafe and potentially abusive situations, and pets are not always friendly.

We are incorporating more complex and difficult cases into our case load. Keeping people out of hospitals is a major part of home care programs, and for those patients admitted to hospitals, fiscal restraints are forcing their release faster than ever. So, on the patient side we face enormous challenges.

We also face challenges on the program side due to the current configuration of home care programs. Currently, the 38 home care programs provide access to physiotherapists' services through several avenues: acute home care, chronic home care, school care.

We are pleased that Bill 173 consolidates all those programs under one delivery mechanism, the multiservice agency.

Currently, eligibility for treatment by a physiotherapist hinges on eligibility criteria for admission to the home care program itself and includes such things as a medical referral from a doctor, minimum service levels, inability to access outpatient care in the hospital and adequate family or care giver support.

The eligibility criteria for acute and chronic home care differ on paper, but more important are the differences in interpretation of eligibility criteria by the various programs, which lead to wide variations in services available from region to region.

This is the maze the long-term care patient must navigate to access services. We are very happy that Bill 173 introduces a seamless approach that eliminates the inequities created by variable applications of criteria for eligibility and provides more streamlined and cost-effective access to services.

Currently in home care, not all physiotherapists are directly employed by the various programs. Many work for independent agencies we contract with to smooth out blips in demand and the regional and seasonal variations.

This out-sourcing has been essential to preserve the quality and integrity of physiotherapy treatments in the home care context, and studies commissioned by the Ministry of Health itself have shown that there is no significant difference in the cost of out-sourcing services from internal services.

In home care we have to be able to be flexible and responsive. The public has to be able to access resources as needed without having to go back to the ministry each time for permission. If we don't, or if we can't, the patient suffers.

Ms Cummings: Our submission was provided to the committee a few days ago, so I intend only to summarize the concerns, issues and recommendations that we discussed in some detail in the submission.

We have four major issue areas and an additional four more minor concerns.

First, while we are pleased as a profession to be listed in subsection 2(7) as a "professional service," we are concerned that Bill 173 does not limit the delivery of physiotherapy service to licensed physiotherapists.

There are many people out there, regulated and unregulated, who hold themselves out as providing some form of physiotherapy or physical therapy, but none has the training, the expertise or the experience to deliver true and effective physiotherapy except licensed physiotherapists. None has the regulatory control and accountability that go with being an RHPA-regulated physiotherapist.

We are very concerned that Bill 173 may expose home care patients to ineffective or even harmful or abusive treatment at the hands of unqualified and unregulated practitioners. This concern is especially germane in the context of long-term care, given that these patients are, in the main, precisely those who are the most vulnerable and the least able or least likely to complain.

However, we do support the ability of physical therapists working under Bill 173 to delegate aspects of treatment to support personnel. There are many times when such delegation not only increases efficiency but also decreases costs. However, in order to have the care that they deliver covered by the regulatory umbrella of the RHPA, it is licensed physical therapists who must have the final decision on what, when and to whom to delegate.

We recommend, therefore, that physiotherapy services, as listed under Bill 173, be delivered only by regulated physiotherapists, or by order by or delegation from those physiotherapists, as is provided for in the RHPA.

Second, we worry that Bill 173 has created a legislative straitjacket in terms of the cap of 20% on out-sourcing of services. We recognize the ministry's concerns about funding and open-ended funding commitments. We applaud the ministry's intent to allow the structure of MSAs to reflect the needs of different communities.

Having said that, we know from experience how much long-term care needs differ from community to community. We think each community should be authorized and encouraged to structure its long-term care programs and services around the individual circumstances, requirements and resources of each community. We know that there has to be sufficient flexibility to respond to a host of variables. We also know that out-sourcing is cost-effective.

We recognize and support that Bill 173 gives the ministry the discretionary powers to approve services and programs in addition to those enumerated in Bill 173, as requested by the community. However, while recognizing the safety valves that are built into the bill, we fear the 20% cap will not allow MSAs to configure their services and programs to particular community needs, will in some cases result in duplication of resources already available in the community and in other cases lead to long waiting lists.

Third, while we very much support a bill of rights for long-term care patients, we have one reservation and one addition. We think that in today's fiscal environment the bill of rights should be circumscribed by reasonableness and resource limitations. I think we all know what happens to the interpretation of bills of rights. They are often interpreted much more widely or liberally than was originally intended; hence, our proposal for some realistic

and reasonable statutory boundaries.

We also think there should be a mirror bill of rights for practitioners. Bear in mind the environments Cathy described for you in which long-term care is often provided: alone, at night, in remote areas, in residences with no telephones and in situations that are potentially abusive and physically dangerous.

We think Bill 173 should include measures that allow MSAs and practitioners to assure the physical safety and security of personnel providing long-term care.

Fourth, we think case management is a service that should be added to the list of professional services. Case management isn't always necessary, but it is critical when a patient's treatment plan is complex and requires different kinds of services and coordination of the many different care givers. Case management identifies to the client, who may be confused by the vast array of people coming into his or her home, the one person to contact about concerns, questions, additional information and so on. Case management, whether done by separately employed case managers or by the service providers themselves, is a time-consuming service that needs to be recognized and accounted for separate from the hands-on professional services to that client.

I must emphasize, however, that the case manager is not and should not be allowed to be the gatekeeper of the long-term care system. The case manager could be any professional delivering care to the patient under Bill 173.

Finally, our four minor issues are listed on pages 12 and 13 of our submission. They are, in brief, that reports under section 20 be delivered in a format comprehensible to the patient, that subsection 37(2) be expanded to include any RHPA-regulated professional and there be provisions to exclude anyone with a conflict of interest, that section 32 expand representation on the Health Services Appeal Board to reflect the range of professions delivering services under Bill 173, and that notices under section 45 be sent by registered mail.

That concludes the summary of our position on Bill 173. Once again, thank you for the opportunity to appear before the committee. We are happy to respond to whatever questions you may have.

1120

Mrs Barbara Sullivan (Halton Centre): I think your presentation is quite interesting. Many of the points you've raised I'm not sure can be answered with amendments to the act, although one might: The case management issue may well be considered as an amendment. Some of them may well be incorporated in the regulations, however,

I too am concerned about those people who are apparently providing physiotherapy services who don't have the qualifications. I think that concern extends not only to the home care situation, but also to other services that are provided. Some of those may well include physician-operated clinics, which are problematic. I've certainly spoken with the minister about that issue on other occasions.

I don't know how the government intends to ensure that it is professionals who are delivering services that

under the RHPA are in fact professional services for which there is a scope of practice and rules and for which there's a discipline. We might want to pursue that.

I appreciate your point about the 20% out-sourcing. It strikes me as affecting the needs that would be identified in a community. By example, in northern Ontario, where work history and clinical needs are quite different than they are in southern Ontario, largely because of the type of injury that occurs there, I'm certain that would be projected in quite a different long-term care need as people age and move into the community. Indeed, physiotherapy services may well be required at a greater level intermittently than would be included in the MSA normal structure. I think that's an important point and in fact we are working up an amendment with respect to that 20% issue.

The work protection issue is one that a number of groups have raised to us. I think only one, if any, has come before the hearings with that particular issue. I think there is possibly something that can be done, either in the legislation or in the regulations or through policy in terms of worker protection. It's a very difficult area because you don't know what you're going to face. As people are in less secure facilities when they're in their own home, the professional abuse becomes more and more of a problem.

I think your brief is a good one. I don't have any questions on it, I guess, other than to ask the ministry or the parliamentary assistant what steps the ministry is taking to ensure that those services which are professional services are in fact delivered by professionals.

Mr Wessenger: One thing that should be made clear is certainly this act does not in any way override the Regulated Health Professions Act. That would still apply and that would be the guideline with respect to who may provide services, whether within or outside of the long-term care system. There's no override of the Regulated Health Professions Act.

Mrs Sullivan: But I think the concern is—and I think that probably in physiotherapy the issue has been raised more frequently than in other areas of professional services, where manipulation is done by people who do not have the qualifications. It occurs now. What steps would be taken to ensure that the professional services are in fact delivered by the professionals and not by a person who is self-described as a physical therapist or uses another title and does the same kind of manipulation or assessment, apparently, that a physiotherapist does and indeed may cause physical damage?.

Mr Wessenger: Yes, I'm quite aware of some of the situations with respect to the clinics you referred to, but I'll ask Mr Quirt perhaps to add something.

Mr Quirt: I think the presenters and Ms Sullivan have brought up an important point. Certainly when we designated physiotherapy as a required service, we were referring to the services of an RHPA-regulated physiotherapist. We do, however, see the involvement of other community service workers in the provision of those services. We would hope that RHPA-regulated physiotherapists would assess client need, develop an appropriate physiotherapy program, instruct other workers in its

application to work with the client, monitor that program and make adjustments to it as necessary. Clearly, in prescribing physiotherapy as a mandatory service, we were not trying to prescribe something other than RHPA-regulated physiotherapy services.

Mr Jim Wilson: Thank you very much for your presentation and, Madam President, I also want to thank you for the physiotherapy association T-shirt.

Ms Cummings: You're welcome.

Mr Jim Wilson: It's great. As I wear it in Wasaga Beach these days, people think I'm a physiotherapist, and I go to great length to explain to them that I'm really not that professional and not covered under the RHPA.

You make an excellent case about the 20% cap on services; in fact, one of the best cases I've seen presented to date. You call the 20% rule imprudent. You talk about, and I think it's again a very good point, the fact that it may—and I'll just quote: "It will force MSAs to incur capital and operating commitments that, in individual communities, may unnecessarily duplicate existing health care resources. In other communities, hard and fast application of the 20% rule will inevitably lead to long waiting lists which are not in the patient's best interests and, in effect, introduce a two-tiered health care delivery system between those who must rely on an MSA and those who can source faster treatment elsewhere."

You go on to make some other very good points about it in terms of it may also affect the recruitment of requisite personnel, professionals, to cover services. I just want you to know that we will be introducing an amendment to just delete all reference to the 80-20 split. It is an arbitrary figure. It's one that in no way can be backed up by this government by any study or documentation. It's simply an ideological attempt by the NDP once again to drive the private sector out of the delivery of health care services in this province. The policy for decades in this province has been to simply allow a balance in the system between the private sector and the non-profit sector, but the government is hell-bent on this approach. Some relief has occurred, though. It was a 10% rule last year and the year before. They've now found the arbitrary figure of 20% to be more suitable.

Would you agree with our amendment? We're going to need support from the public at large to try to convince the government to just scrap any reference to what clearly is an arbitrary rule that has no backing whatsoever in fact.

Ms Cummings: We support that individual MSAs should be able to select the services and the way the services are staffed according to the resources and the needs of the community. Taking away the 80-20 rule will allow the MSA to do what fits the community best.

Mr Jim Wilson: It also seems to be even more ridiculous when you consider that the government pays the same rate for your services whether you come from a private-sector agency or a non-profit agency. When we had one of the unions in here the other day, we simply asked them, "If the government pays the same rate and that's the only source of revenue"—these community-based services that a private-sector agency is providing—

"then how is it that you feel they're making a profit in health care?" They simply could not answer that. They said, "Well, the profit has to come from somewhere."

Logic tells you if there's one revenue stream and it's coming from the same base as the non-profit agencies, I mean the same fee, one comes to the conclusion that having the private sector involved in the delivery of health care services—it's been the policy, as I said, for decades in this province—introduces a degree of competition and helps keep costs down across the board. In fact, thank goodness many of the non-profit agencies and associations such as yourselves have come forward and said it's just a ridiculous rule.

1130

I want to know also, because it's been brought forward as a contentious issue—there are a lot of rumours flying around that currently unionized employees, whether they be physiotherapists or—I don't know whether you have any physiotherapists in a unionized environment but I assume you do in many cases—will get preferential treatment because the unions are cooking a backroom deal with the government that their people will get jobs in the new bureaucracies and the new MSAs, but that those workers, and it's a significant bloc if not the majority of workers, who are not covered by collective agreements will simply be shut out of this process. Do you have any thoughts on that because we're looking towards putting some job security amendments in this legislation.

Ms Cummings: I hadn't heard that. I think physiotherapists, still being a resource that is finite and perhaps not as plentiful as some other professions, will make that kind of approach quite difficult.

Mr Larry O'Connor (Durham-York): Thank you for coming before us and making a presentation. There are a number of areas you touched on where I think you've raised some concerns, some fears maybe that you have that aren't real. I know we could listen to my colleagues and sometimes the rhetoric overtakes us here. They're concerned about job security. The reality is that since 1991, 5,000 jobs have been created in this sector. There's been an increase from \$550 million, from 1991, to this year, \$850 million. So the reality is job creation. The proof is in the pudding because the money's on the table and it's out there in the field and it's providing the services.

The assessment mechanism and case management—there has been a working group and, unfortunately, not all the members even know all the work that's gone into the legislation because we haven't had a technical briefing for all my colleagues at this point, but we're going to have that. Hopefully, we can get agreement and we can do that maybe tomorrow.

There's been a working group and on that working group and taking a look at assessment has been the Ontario Home Care Case Managers Association. Correct me, but I think that is the avenue on which physiotherapy is now directed to the needs of the client, the consumer in this case. What is the referral process that would allow a physiotherapist's service to be provided in a home setting today?

Ms Cummings: Currently?

Mr O'Connor: Yes.

Ms Cummings: It's on a physician referral basis and if the physician makes the referral for physiotherapy, the case manager then receives that referral and contacts the physiotherapist or physiotherapy service and arranges for that to happen.

Mr O'Connor: Okay. In the working group that is trying to take a look at making sure we can develop a consistent, right-across assessment process so that everyone is going to have access to the services that you provide, the needed service that you provide, one respecting the clinical discipline that you represent—there's been a broad range of people who have been included in that, which has included some physician representation there.

The concern that you have I think is real; it does need to be included in that process. I think it's being met, though. There is a group meeting to try to define that a little bit better and if there are any suggestions you might have to improve what we've got in there, I'd appreciate any thoughts you might have. We do have a lot of work going on there and I guess not all my colleagues know of that work because they haven't had the briefing that they could—

Ms Cummings: We don't necessarily support that case management be done by a separate group of practitioners called case managers. I would wonder if there are professions other than already-established case managers in your working group.

Mr O'Connor: There are. There are a number of different home nursing programs. I'll go through the group, okay? I'll give you a list: the Alzheimer Association, the francophone one, the Ontario Home Care Case Managers Association, the Ontario Federation of Labour, the Association of Placement Coordination Services of Ontario, the Integrated Living Association of Ontario, the Advocacy Centre for the Elderly, the Red Cross, Ontario division, the OHA, the Ontario Community Support Association, the Community Occupational Therapists and Associates, the Multicultural Alliance for Seniors and Aging, Riverdale Immigrant Women's Centre, the Victorian Order of Nurses, the Ontario Medical Association and some consumer groups, and I don't have a list of who all those consumer groups would be, but it's a fairly broad-ranging group.

I guess the difficulty is you could create a group that's going to be so large that it's hard to get them to focus on what the important thing is, the assessment of the consumer, that the needs the consumer has are going to continue to be met in a more effective way than has been in the past, because in the past we had the 38 home care agencies out there directing it and not everybody has been covered as well as they could have been.

Ms Cummings: The OPA recognizes that you're addressing the assessment needs. However, case management for physiotherapists working in home care, actually, we see the focus being more of coordination, advocacy, ensuring good communication between all the service providers in the home rather than assessment and screening and gatekeeping and that kind of thing.

Mr O'Connor: Yes, I think—

The Acting Chair: Thank you.

Mr O'Connor: —that was actually presented quite well. The only other point that I'd like to make—

The Acting Chair: Mr O'Connor, I'm sorry.

Mr O'Connor: —is that the 20% doesn't necessarily affect physiotherapists, because it's my belief that most of them are individuals, in which case you're purchasing a service and there's an exemption for a purchase of service within the bill.

Mrs Sullivan: Could we have a clarification of that from the ministry officials? It might be quite misleading.

Mrs O'Neill: I think that would be very interesting.

The Acting Chair: Can you make that response briefly, Mr Quirt?

Mr Quirt: I'll do it as briefly as I can. There are some—I wouldn't say the majority, but some—physiotherapists and occupational therapists who work as private practitioners. The bill's provision that limits purchasing to 20% excludes the purchase of services from an individual. So, for example, if an MSA had already used up its 20% of purchasing professional services in buying nursing services and it wished to contract extra services with an individual physiotherapist, it could do that without worrying about going over its 20% limit.

Mrs Sullivan: It's in the interests of physiotherapists to go out on their own.

Mr Wessinger: Mr Chair, a point of order: Mr Wilson made an allegation with respect to there being some special backroom deal with respect to getting special preference to union members and I'd like to be clear that there's no basis for that statement and if he has any evidence of it I wish he'd put it forward.

The Acting Chair: Thank you.

ONTARIO HOME RESPIRATORY SERVICES ASSOCIATION

The Acting Chair: Our next presenters are representatives of the Ontario Home Respiratory Services Association. Welcome to the committee. Please introduce yourself before beginning.

Mr Blair Richardson: My name is Blair Richardson and I'm the executive director for the Ontario Home Respiratory Services Association. I'm pleased to be here this morning and to present our submission to the standing committee.

I want to spend a little bit of time this morning talking about the services we provide and the system within which we work, because it's our experience within that system that leads us then to provide some observations on Bill 173, the long-term care reform, and also some recommendations.

Our association represents the private-sector providers of home respiratory services. Our association dates back to 1985. We provide services to approximately 20,000 people per year, all in a home setting. The largest source of revenue for our industry is the Ministry of Health's home oxygen program. In the current fiscal year, it has a budget of \$70 million. The home oxygen program is funded under the Ontario drug benefit program and it is

administered by the assistive devices branch, which is also responsible for the assistive devices program. OHRSA members in fact provide services to over 95% of the HOP case load.

1140

Our association's goal is a private sector home respiratory services industry that is viable and that has an opportunity for future growth, and in order to achieve that goal we recognize that a number of things must be happening. First of all, there has to be widespread recognition that the services we provide are both efficient and cost-effective; that we have a reasonable reimbursement for these services; that there's fair competition among service providers approved by the Ministry of Health and, lastly, that the association works on an active and progressive basis for change in the health care system.

Pioneering work was undertaken by our association some years ago in collaboration with the Canadian Council on Health Facilities Accreditation and partly funded by a grant from the Ministry of Health. This pioneering work led to the establishment of a national accreditation program for home respiratory services and it's the first national accreditation program for any home care service. We're very proud of this accomplishment and we feel that it does in fact demonstrate our strong desire for continuous improvement in the quality of services that our members provide to home oxygen therapy clients.

What basic services do our members provide? Well, the basic service we provide is home oxygen therapy which also includes respiratory care. It's provided to individuals with lung disease or cancer when their lung function has deteriorated to the point where they need supplementary oxygen. There's no cure for lung disease but oxygen therapy has been shown to be effective in reducing mortality based on large multicentre trials conducted in England and North America. I might add, the effectiveness of oxygen as a drug is perhaps not shared by all the other drugs that are listed under the Ontario drug benefit program.

In addition to home oxygen therapy, members provide a range of other services, again, all focusing on respiratory disease and the provision of respiratory equipment and professional services, either by respiratory therapists or in some cases by nurses with special respiratory training.

What happens when a person requires oxygen therapy? We've listed here the basic steps in the process in Ontario. First of all, the attending physician writes a prescription, which in turn is based on his work and both home oximetry tests or arterial blood gas test results. Then a service provider is selected by the physician and the client from among those who are under contract to the Ministry of Health. The physician fills out an application form, which is sent to the ministry, showing that the individual has met the eligibility criteria set down by the ministry.

The Ministry of Health admits the person to the home oxygen program and then the service provider makes a visit to the home to install the oxygen therapy equipment,

to do a home assessment to make sure the home is a safe environment for the equipment, and then provides teaching on the safe operation of the equipment, the hazards of the equipment, and also answers questions about the disease and any other concerns that the client may have. By contract, the service provider is available 24 hours a day, seven days a week, to respond to client problems.

Following the installation of the equipment, the respiratory therapist makes regular home visits in order to monitor the patient's compliance with the physician's prescription, to observe if there are any changes in the client's condition that will require the physician's intervention, and also to make sure that the equipment is functioning properly.

These services are then reimbursed by the Ministry of Health according to the fee schedule which is in the contract.

The home oxygen program has a number of strengths which we would like to highlight, because we think they're relevant to the current debate about Bill 173. First of all, the physician is free to choose the equipment configuration that best meets the client's needs in discussion with both the client and also the service provider.

The client has a choice of service providers regardless of where they live in the province and usually the client seeks the physician's advice in terms of service providers. But, of course, the ultimate decision is always the client's.

Competition is very keen among the service providers solely on the basis of service levels, because the reimbursement levels for home oxygen therapy are set on a province-wide basis. All the service providers receive the same reimbursement, so then competition to differentiate service providers is purely on the basis of the level of service they provide.

I think the most significant point here is that there's a short feedback loop from the client to the physician. If the client is happy with the service that the client is receiving, then usually this is conveyed to the physician during one or another office visits, and so the physician has a very accurate and up-to-date knowledge as to what level of service is provided by the various providers, and they make excellent use of that information in terms of where they send their future referrals. If a company is providing less satisfactory service than some of their competitors, they usually then find that they're getting a lot fewer referrals from particular referring physicians.

Lastly, there's good coverage for the program in Ontario. In other words, if a person does in fact need the service, they're very likely to be able to get it because both the physicians generally are aware of the existence of the program and government payment for these benefits, and also because there's good geographic coverage provided by service providers.

In terms of program results, I'll just highlight a few points. We think the availability of this program on a home delivery basis has had an impact on the rate of institutionalization. The Ministry of Health has told us in fact that there are only 400 people on oxygen therapy in

nursing homes and homes for the aged.

For nearly half the people who are on oxygen therapy, the specialized equipment that they receive enables them to go outside the home on a regular basis. This is very important to them both in terms of the quality of their life, and also their ability to conduct activities of daily living. The close follow-up at the home by the RT or the nurse ensures good compliance with the physician's prescription, which is directly related to mortality rates, and it also allows for the early identification of changes in the client's condition. This helps to prevent acute respiratory problems and the need for hospitalization.

What are OHRSA's concerns about Bill 173? We're concerned about the MSA model. We think that in effect the MSA will become a monopoly for a specific local area and it will also have stringent limits on contract service provision. The home oxygen program experience that I've touched on briefly demonstrates that competition among service providers is the key factor in the quality of service that clients receive.

Secondly, while we do acknowledge the need for changes in the long-term care system, OHRSA's second concern is whether the long-term care clients will be better served in future when this major reform has been fully implemented. Having listened to some of the discussion yesterday afternoon, perhaps some of the people around the table here will feel that we're just another group of service providers who are interested in preserving the status quo and are unwilling to consider that some changes might be for the better, and in fact are unwilling to fairly consider the evidence that these changes might be for the better. It makes me think of tobacco companies denying that there's any link between smoking and lung cancer, but I don't think that's the case here.

The analogy I would like to draw is with computer equipment. Let's suppose for a moment that you're the CEO of a non-profit agency providing home care services. You have a computer installation which is very important to the day-to-day running of your agency and through your front door one morning comes a computer salesman and he says: "I want you to sign this contract to purchase a new computer system. It's going to replace the one that you have now. It's going to be wonderful. It's going to have all of these advantages. We're only in the design process for this new computer but I want to assure you that all of these benefits will in fact occur, and would you please sign here."

I think you would agree that any CEO in that kind of circumstance would probably consider very carefully the claims this computer salesman was making for the equipment, and might be quite sceptical that the promised benefits would in fact be delivered. Certainly, the greater the change promised in terms of the new computer system, the more risk there would be that in fact perhaps those benefits might not be delivered.

Just to belabour my analogy a little more, supposing after the salesman leaves, the CEO then turns around to his chief financial officer and this person says: "I have a lot of experience with computer systems. In fact, I worked for this company some years ago. I know their track record. I'm familiar with some of their research and

development people, and I feel quite confident that the promises that are made in terms of this new computer equipment will in fact be delivered."

I think there, again, the CEO's view of the situation might be coloured by the advice that he had received from his chief financial officer.

1150

Even though one of the criticisms that's been levelled at the long-term care system is that it's provider-dominated, I think it still is important for the decision-makers—you people here—to consider the input of the service providers in a balanced way, because their knowledge of how the system works and their ability to assess the benefit of various proposed changes I think is pertinent.

In a positive vein, therefore, OHRSA has some recommendations to make. First of all, as we all know, there is a planning effort under way now through the district health councils. We recommend that before any funding flows to local agencies under this Long-Term Care Act, the ministry first take a look at those planning results and, on the basis of that, set out a description of the expenditure that's going to be required to implement the long-term care changes throughout the province; and that, secondly, the ministry provide a description of the savings and the other tangible benefits that will occur, once the new system is in place. This would in fact provide a benchmark against which to measure progress and it will also enable the minister to be held accountable for results.

The second recommendation: Since the implementation of long-term care changes will not occur simultaneously, this provides a good opportunity for an evaluation of the first MSAs that come on stream. We recommend that a proper evaluation be undertaken at a handful of sites. This evaluation should confirm tangible benefits before the long-term care reform in fact goes province-wide. Evaluation results from the early sites should also help later implementation sites avoid some of the implementation problems.

Our third recommendation relates to section 13, which places a cap on contract services. We recommend that section be deleted until such time as it can be demonstrated that the MSA model is less costly or more effective than what's referred to as the brokerage model in Ontario.

That essentially is our presentation. I would like to thank the committee for the opportunity to make these comments. I would be pleased to try to answer any questions which you may have.

Mrs Sullivan: We appreciate the brief you've prepared. I think you've raised some of the issues that are of some concern to members of the committee, not the least of which is, firstly, the cost of the new system and whether those costs have in fact been projected with any kind of accuracy or viability; and, secondly, whether the promises that have been made through raised expectations in association with statements that have been made about long-term care reform will in fact be funded through what we've been told will be a negotiated mechanism for

determining how much money will go to an MSA. So I think those are questions which are pertinent and are very much on our minds.

I am wondering—and I am going to ask the ministry to respond and you to respond—if there has been any movement at all to bring home oxygen services under the aegis of the MSAs or if that is contemplated in any way and what steps you would see as necessary if that were taken.

Mr Wessenger: I'm going to ask Mr Quirt to reply on that.

Mr Quirt: The short answer is no, we'd expect that oxygen therapy would continue to be prescribed by a physician, that the drug itself would be subsidized by the Ontario drug benefit program for clients eligible for that support and that the assistive devices program would continue to administer that.

MSAs may well, in their information and referral capacity, suggest that a client might speak to his or her physician about a particular therapy, but that would be the extent to which MSAs would be involved in that transaction, I would think.

Mrs Sullivan: I appreciate that response, and I think that probably your association will appreciate it as well.

Mr Norman W. Sterling (Carleton): In terms of the services which you and your members provide to the public of Ontario, what percentage of the total does the private sector provide now and what percentage would hospitals provide, for instance? Have you any idea what the percentages would be?

Mr Richardson: There are three hospitals that provide these services and they would collectively provide probably about 1%.

Mr Sterling: So the private sector is taking care of, let's say, 95% of—

Mr Richardson: Yes.

Mr Sterling: —the needs of these people in Ontario.

If MSAs are required to have this 80-20 split, your industry's going to come under considerable attack, or the private sector, part of it, is going to come under considerable attack as the squeeze occurs for the MSAs to show the 80-20 split. Is there any movement afoot on the part of some of your private operators to switch over to non-profit and take the profit out, as many non-profit organizations are through high executive salaries and that kind of thing, which has happened in day care and a number of things when governments go through this money switch?

Mr Richardson: Members of our association aren't making any of those changes because, as Mr Quirt explained, it is not contemplated that the types of specialized services that our members provide would be rolled up under the MSA.

Mr Sterling: So you're not going to be required to have the 80-20 split for your services?

Mr Richardson: No.

Mr Sterling: You won't be rolled into the total budget of the MSA then?

Mr Richardson: No. It's my understanding that we won't be.

Mr Sterling: Is that in the legislation or is that by exemption?

Mr O'Connor: Section 13.

Mr Sterling: Okay. I have no further questions.

Ms Carter: Obviously you do provide vital services and equipment and part of what I had to ask has already been answered, but I'm just going to push this a little bit further as far as actual information from the ministry goes.

I still wonder whether there are not chronic conditions that might come under the MSA and, if they did, I understand that equipment does not come under the 80-20 limitation. That would come under the assistive devices program, but that still leaves the nurse, or whoever is there, in some circumstances to administer it. How would that work if, in fact, some patients did come under the MSA? Are there patients in that category?

Mr Wessenger: I'll ask Mr Quirt to perhaps explain that and also deal with the issue of equipment in general, which is how it's dealt with under the—

Mr Quirt: Currently, the home care program does provide its clients with equipment necessary for some chronic conditions and to assist in providing their services if they're an acute care client of the home care program. The MSA would continue to do that and the costs associated with that would be, as they are now, covered 100% by the province.

There are some pieces of equipment, however, that individual clients are provided with where the equipment is maintained as the property of the individual client. A wheelchair would be an example and the assistive devices program, in addition to administering the oxygen program that our presenters described, does provide 75% of the cost for a number of those pieces of equipment like walkers and wheelchairs and so on.

The multiservice agency, if they recognized that a client needed that kind of permanent type of support in their home, could make the referral to the assistive devices program and a supplier that contracts with the assistive devices program in each community would provide that service and the client would be reimbursed for 75% of what I understand to be now a fixed amount for each particular type of equipment.

1200

Mr Jim Wilson: It's important that we know what's included in the 20% of accrued budget rule for these community services, and I'd just like a clarification from Mr Quirt.

Would that mean that everything under the ADP, because it's budgeted for—

Interjection: Separately.

Mr Jim Wilson: —separately in MOH, everything under the ADP would not in any way constitute—those services or equipment would not constitute part of the 20% accrued budget rule?

Mr Wessenger: Yes, that would be correct. I think there's also an exemption for that equipment that is already provided under the bill. That's excluded also from the 20%. In other words, as you know, some of the

agencies now provide such things as, I think, safe wheelchairs and so forth for temporary use for somebody who's—

Mr Jim Wilson: Then what purchases in terms of, say, non-treatment or personnel services—what purchases of equipment or supplies or whatever, fall under the 20% rule?

Ms Gail Czukar: Equipment and supplies and so on are excluded from the 20% rule for precisely the reason that MSAs shouldn't have to maintain an inventory of equipment or specialized equipment, in particular, and so on. So they are excluded from that rule and they're also excluded from the list of mandatory services that have to be provided.

Mr Jim Wilson: What about in the case of charts that I brought up in the Legislature, where the government clearly has already ruled that computer services contracted out, which are part services, one could argue, certainly fell under the current 10% rule, or contracting out of other similar functions which are essential pieces of equipment, as it were, or essential functions to the operation of an MSA, for instance?

Ms Czukar: The 20% rule applies to services, so it's the services that are included in the four categories. It doesn't apply to administrative services or support services: payroll, administration and that sort of thing. Those can be purchased by the MSA without going into the 20% category.

The Acting Chair: Thank you, Mr Richardson very much for your presentation.

If the members of the committee would stay just for a couple of minutes, we can deal with a couple of procedural matters before breaking for lunch. Firstly, the clerk advises me that you'll be all provided later this afternoon with either tickets—how are we getting to Hamilton?

Mrs O'Neill: The bus.

The Acting Chair: The bus? For those of you who are driving, there'll be a memorandum with a map telling us where we're going and how to get there; otherwise we'll be boarding a bus at 8 o'clock tomorrow morning.

Ms Carter: Where?

The Acting Chair: At the front door of the main Legislative Building.

Secondly, many committee members have expressed an interest in having a technical briefing. I think we should have that sooner, rather than later. I wonder if we might have agreement to have that briefing tomorrow during our hour and a half lunch period in Hamilton. I think if we set aside one hour during that time, that would be sufficient to allow for a presentation in the order of approximately one half-hour, followed by questions. Is there agreement to that effect? Agreed.

The other thing Mr Quirt is seeking is some direction, some guidance, with respect to the nature of the briefing. Eligibility criteria have been raised. I understand that would consume a great deal of time in and of itself. There's also the original briefing, which has yet to be given, which had been scheduled for the opening date.

Mr Jim Wilson: Mr Chairman, the original briefing started off as more of a defence of the bill than certainly a technical briefing. If the offer is for a true technical briefing, I would agree with your suggestion and also ask that other topics include such things as the regulations, where we are with many of the regulations to date, because it's a whole section of the bill which obviously—when one reads it, one's unable to really figure out what's going on.

Also, I would like—and I guess we'll get to it if we go in some sort of numerical order through the clauses or something—district health councils. We've had no discussion to date in committee about the new legislative mandate and role of district health councils.

Mrs Sullivan: I would prefer something that is technical in terms of issues that are raised in the bill and less of an exposition of the proponents' view of the bill, which I think we were starting to get in a technical session the other day. I think there are numerous questions with respect to the interim period that's identified in the bill: what is an approved agency; how they will be approved; what the criterion are. Most of the unanswered questions relate to what is projected to be included in regulations, and I think that for greater understanding and clarity, we have to know what direction the ministry is going in to ensure that what is covered by the regulations is in fact what we want to see reflected through the legislation.

Mr O'Connor: I agree that we need to have that technical briefing so we can go through the bill and all the clauses and why they're there. I think that's very necessary. The other thing I think would be useful for the committee would be an update then on some of the working groups, because when we talk about eligibility and assessment, some of that hasn't been included because some of the work is yet to go, which will go into the regulations, so maybe an update on the working groups as well that's under way.

The Acting Chair: All right. Mr Quirt, legal counsel, you've heard the needs of the various committee members and I trust you'll take that into consideration. Thank you. The committee stands adjourned until 2 this afternoon.

The committee recessed from 1206 to 1410.

CANADIAN RED CROSS SOCIETY,
ONTARIO DIVISION

The Acting Chair: Good afternoon, ladies and gentlemen. Welcome to the continuing hearings on the matter of Bill 173, An Act respecting Long-Term Care. I'd ask our first presenters to please come forward and take a seat, representatives of the Canadian Red Cross Society, Ontario division. Welcome. While you're taking your seat, I want to remind all of our presenters and the committee members that we've allotted one half-hour for each presentation. During that time we ask that you make your presentation and, if at all possible, allow time for questions and answers. You'll find that all the committee members have a real interest in the issues that you're dealing with and we'd like to have the opportunity to do a bit of probing.

Mr Bob Morton: My name is Bob Morton. I have

the pleasure and honour of being the president of the Ontario division of the Canadian Red Cross Society. Joining me today is Mrs Nancy Bell, chairperson of our homemaker services. One of the ways in which we organize our program is through program committees. We have submitted a brief to you. I would like to begin to present our brief on page 5, to talk a little bit about the Canadian Red Cross Society, and Ontario division in particular.

We have some specific amendments and some specific areas that we would like to talk to the committee about with respect to potential amendments. Nancy will speak to those and then I will conclude with some closing remarks. I believe that will allow some time for questions when we're done. Let me begin.

The Canadian Red Cross Society is a member of the International Red Cross and Red Crescent Movement. One of the fundamental principles of the movement states that there can only be one Red Cross in any country. The society is a non-profit, charitable corporation incorporated under federal law. In each of the provinces there is a division. The divisions are not separately incorporated and are accountable through the secretary general to the board of governors of the society.

The Ontario division of the Canadian Red Cross Society operates 78 local branches, almost all of which run community-based long-term care programs. In accordance with the mission of the society, each of these programs has been developed in response to needs identified by the local community. Particular emphasis is placed on ensuring necessary services are available to the vulnerable members of those communities.

At present Ontario division offers a wide range of programs throughout the local branches, and the statistics are somewhat overwhelming. There are over five million hours of homemaking provided through 52 branches and satellite offices, about half of the homemaking service provided in the province of Ontario; the society operates 16 meal programs—12 Meals on Wheels and four Wheels to Meals programs; there are 16 transportation services programs; we have one care giver support services program; there is one adult day care program operated by the society; there are five home maintenance programs, 12 friendly visiting programs, eight security programs, one personal emergency response program, seven telephone assurance/postal alert programs; there are 16 fun and fitness programs operated by society members in the province; and there are 63 branches providing home health care equipment loan services.

In all, these services are provided to more than 130,000 Ontarians through the efforts of over 10,000 volunteers and over 6,000 paid staff members.

Our wide variety of programs and services allows volunteers with diverse backgrounds and interests a variety of opportunities to participate in the society's humanitarian efforts. Working together, volunteers and staff are partners in implementing our mission through the programs we offer.

With those thoughts in mind, we'd like to offer some specific comments about the proposed reform, and in particular Bill 173.

The Ontario division of the Canadian Red Cross Society applauds the government for its effort in proceeding with long-term care reform. We strongly support the principles and goals outlined in *Partnerships in Long-Term Care: A New Way to Plan, Manage and Deliver Services and Community Support*. These principles and goals were identified through an extensive consultation process with key stakeholders, a process in which the Red Cross was proud to participate. However, there are some sections of the current draft of Bill 173, An Act respecting Long-Term Care, that do not seem to reflect the stated principles and that are of concern to us.

We welcome the opportunity to comment on Bill 173. There are several issues of particular interest or concern to us that we will specifically address in this submission.

We strongly believe that legislation must be enabling rather than prescriptive. Legislation which is enabling will be relevant well into the future. If legislation contains too much detail, it becomes inflexible. Legislation must be flexible if it is to withstand the rapid evolution facing long-term care and allow service providers to meet the changing needs of their diverse communities. Time doesn't permit me to discuss this issue, but perhaps through questioning we can talk about some specific examples of how we feel legislation should be enabling rather than prescriptive.

It's our view that enabling legislation is essential if all partners involved in providing community-based long-term care are to develop new and innovative structures and processes that will lead to genuine collaboration and a seamless continuum of services that is effectively and efficiently provided.

We also recommend that the legislation respect the principles and traditions of the volunteer agencies that provide community-based long-term care services. These agencies are deeply rooted in their communities. Many of the services that they provide have been developed in response to the community's unique needs. These services often have been developed by dedicated and visionary members of the community who chose to volunteer their time and donate their money to ensure that needs were met. We cannot even begin to measure the value of the countless hours of their time donated to meet the needs of their communities and the vulnerable individuals within the communities.

The Canadian Red Cross Society operates in keeping with seven fundamental principles: humanity, impartiality, neutrality, independence, voluntary service, unity and universality. Based on our mission, one of the goals of the Ontario division of the Canadian Red Cross Society is to develop throughout Ontario health and social service initiatives directly related to the needs of the people of the province. Our operating principles require us to make those in need, particularly the vulnerable, our first priority. Where our help is needed, we are required to deliver high-quality, professional services. In responding to our mission, we are often the only provider of services in remote and sparsely populated areas of the province.

Although we support the principles underlying the reform and the purposes as delineated in Bill 173, we are not able to support the creation of multiservice agencies,

MSAs, as described in the act. We are concerned that the proposed system will not improve the delivery of services to consumers. We are also concerned that the legislation is trying to fix problems with the service delivery system through the creation of complex and highly prescriptive organizational structures. We suggest that to be effective, any reform must focus on system-wide changes and avoid micro-managing the operation.

The province-wide consultations held over the past several years clearly underline the need for improved access to and coordination of the existing system. The outcome of the consultations did not seem to call for changing the system itself; it called for improving and correcting it.

The existing system has many strengths. We are concerned that with the creation of MSAs as described in these acts, some or many of these strengths will be lost. The province-wide mandate of the Red Cross has enabled us to identify a number of opportunities to initiate systematic changes that would build on the system's existing strengths, increasing efficiency and improving quality.

The mandate of the MSA makes it responsible for delivering an extremely broad range of services. Our experience in the health system has shown that where acute health care services compete with long-term, non-acute or social services, the latter services are usually relegated to second place. Where MSAs are created, their operating plans must ensure an equitable distribution of resources. Also, a significant proportion of the clients of an MSA will be users of hospital services. To meet the needs of these individuals and to maximize the efficiency of the hospitals, there must be a simple and effective interface between each hospital and all of the community-based long-term care services in its catchment and referral areas. The proposed structure for MSAs does not appear to address this important need.

1420

The legislation as it is currently drafted precludes the Red Cross, its regions, branches or programs from becoming an MSA or providing services as part of an MSA. Notwithstanding, the Red Cross is committed to meeting the needs of vulnerable individuals in our communities, building on the range of services that we have developed over the last 75 years.

The Ontario division of the Canadian Red Cross Society is not a distinct organization but is part of a nationally incorporated entity, the Canadian Red Cross Society, which in turn is part of the International Red Cross and Red Crescent Movement. The Red Cross has had a long history of effective and efficient service throughout the world.

There cannot be more than one Red Cross in any country. We operate under the bylaws established by the society. These bylaws describe authority and organizational structures and set parameters for our operation. The society has only one board of governors. The board is ultimately responsible for the overall direction and operation of all aspects of the society. No agreement or arrangement may be entered into that will in any way diminish the authority of the society's board or impinge

on the society's fundamental principles, particularly:

Independence: The movement is independent. The national societies, while auxiliaries in humanitarian service of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the movement.

Unity: There can only be one Red Cross in any country. It must be open to all. It must carry on its humanitarian work throughout its territory.

The legislation requires that each MSA be incorporated under the Corporations Act, Ontario, or the Co-operative Corporations Act, Ontario. Each MSA must have its own board of governors selected in accordance with the act. These requirements are incompatible with the fundamental principles and the corporate structure of the Canadian Red Cross Society.

We'd now like to make some specific comments. I'll ask Nancy to carry on from there.

Mrs Nancy Bell: When I read the purposes of the act, the purpose that jumped out at me, and the one that we're not doing now, is to simplify and improve access to services. MSAs are designed to provide services and information about services available in their community.

As the daughter of parents who require and are receiving services, information that can lessen the confusion about what's available, how to get it, whom to call, will be greatly appreciated. My parents, Earl and Gladys Bell, have had the following in their home at various times: a Red Cross homemaker, a VON nurse, a speech pathologist, a home care case manager—in fact, more than one—someone from assistive devices, a Red Cross manager and the lifeline representative from the local hospital.

When I called my mother to ask her permission to use her as an example, she added two more to the list: a physiotherapist and, recently, someone she doesn't even know who came into her home and went through the whole thing again. Now, mom thinks she's pretty aware and pretty bright, and she is, but she said to me that something has to be changed. She is totally confused about who's who and whom to call.

We, the Red Cross, have three recommendations that we would like to make which we believe will not hurt the purposes of the act but will enhance the delivery of long-term care.

Our first recommendation deals with the part of the bill that divides services into four categories: community support, homemaking, personal support and professional services. In the past we've had community support, homemaking and professional services, but there's now a new category called personal support.

We believe that by putting care into categories the bill does not reflect the present reality or the changes that are going on. Separating personal care and non-personal care will not be practical, and in fact many activities are both. For example, assisting a client to have a bath will be personal support, but cleaning the tub after is homemaking, under the four categories. Over the past few years we have worked very hard to erase the perception,

the misconception, that homemakers are nothing but cleaning ladies. Homemakers have begun to achieve recognition as a valued member of the health care team.

Bill 173 also states that no fee will be charged for personal support services or professional services, but it does allow for a fee to be charged for homemaking and community support services. We feel that many of the personal support and homemaking functions are interdependent and it's not appropriate to use these categories for imposing user fees.

Therefore, our first recommendation is that the legislation be reworded to eliminate the specific reference to and the categorization of community services, that the regulations to the act be used to define those services to be provided by an MSA and that the act and regulations respect interrelationships between services.

Our second recommendation refers to the section of the act which says that an MSA can purchase up to only 20% of each of the four categories of services. As you know, at present home care programs purchase most of the services they provide. We know there are problems with the current system, but we believe those problems are from lack of coordination and poor access. Rather than replace the present system, we believe we should build on its strengths.

Under the 20% rule our service would gradually, or perhaps quickly, decline. As a chartered accountant who has seen many businesses of all sizes, I'm worried that this section of the act would limit the purchase of service to 20% to the point where we will not be able to exist. Although the rate, we trust, will always cover the homemaker's salary and the homemaker's benefits, at some point in time the volume will not be big enough to pay for the bookkeeper, the manager, the telephones. The Red Cross is very concerned that people like my mom may face waiting lists, a decline in quality of service and limited or no choice.

Therefore, our second recommendation is that the legislation be reworded to remove limits on the amount of service that an MSA may purchase and that the legislation enable each community to choose the best service delivery model and optimum mix of provider agencies to meet the needs of its residents.

Our third recommendation deals with the section which requires MSAs to comply with the legislation within four years. We believe that this provision reduces flexibility. As MSAs will have no choice about their service in four years, they will not be looking for other, perhaps better, ways to serve their clients.

The government has stated that there will not be a cookie cutter approach, but under the legislation at the end of four years the MSA cookies are going to look essentially the same.

Therefore, the Red Cross recommends that the legislation be reworded to eliminate the requirement for MSAs to comply with the provisions of the act within four years after being designated as MSAs and that the legislation enable each community to develop and implement the model of community-based long-term care that best meets its unique needs and culture.

1430

Mr Morton: I'd just like to conclude with a few remarks. The Canadian Red Cross Society, Ontario division, genuinely hopes that changes brought about by long-term care reform will not preclude us from continuing our over 75 years of providing service in our communities. Through our comprehensive range of programs, we are fulfilling our mandate to support the frail and vulnerable, enabling them to live with dignity and as independently as possible in their homes.

We are also proud of the Red Cross's contribution to the professionalization of the role of the homemaker. This occupation, primarily filled by women, continues to evolve. Red Cross, employing almost 6,000 homemakers, is the largest employer of homemakers in the province and is committed to continue to provide leadership to the industry. Our comprehensive provincial programs for quality management and risk prevention set standards for other providers. We continue to develop training programs and resource materials to support our homemakers, improving their level of skill and ensuring the best possible quality of service.

We commend the government for proceeding with long-term care reform. We support the principles and goals outlined in Partnerships in Long-Term Care and the purposes of Bill 173. However, we are disappointed that the draft legislation does not demonstrate the vision that we feel is necessary for such an important task. The role of government is to provide the leadership to move the province into the future. In our view, the bill is unduly prescriptive and will not take long-term care into the 21st century.

As we have noted, we have grave concerns with the intent to address systematic problems through creation of new corporate structures. The proclamation of the act, as it is drafted, will force the Red Cross, and most likely many other voluntary organizations with a proven history of services to the people of Ontario, to immediately begin a major review to identify other strategic directions. The Red Cross is committed to meeting the needs of vulnerable individuals in our communities.

Red Cross is ready to play a constructive role in the future of community-based services within Ontario. We have demonstrated our willingness to cooperate with other providers to improve services in our communities. We have identified a number of initiatives that we feel would increase the efficiency and effectiveness of service provision and are willing to provide leadership in implementing these changes.

We're available for questions.

Mrs Sullivan: I'm interested in a number of the points that you've made in your brief and concur that the ideal approach would be to have enabling legislation rather than highly prescriptive legislation that could particularly meet and recognize the diversity of need across the province.

I'm very interested, however, in the issues that you've raised with respect to your incorporation and your particular legal status, in that the bill has such a legal surround that in fact you are precluded from either being

an MSA or being a provider of services, including even the 20% of services, it appears, that an MSA can purchase outside of its own aegis.

I wonder if the ministry would comment on the particular situation of the Red Cross, which provides an enormous amount of home care services, including in my community, of long-standing quality and is completely eliminated from the long-term care process.

Mr Wessinger: If I could just comment on that, I'm going to ask legal counsel to respond, but I understand that it's not precluded from purchasing services from the Red Cross. I might ask legal counsel to indicate the status.

Ms Czukar: It's true that the Red Cross would be precluded from being an agency within the definition in the act, because of the requirement of a provincial incorporation, but it's not precluded from being a service provider, and certainly could continue to be a service provider, from which services are purchased within the 20% limit.

Mrs Sullivan: That is not the reading. The "service provider" in the act explicitly includes the minister, an approved agency, a person who provides a service with certain kinds of payments and a person who provides a community service which is purchased by an approved agency. The Red Cross cannot be an approved agency and therefore cannot be a service provider.

Ms Czukar: It can be a service provider because it can be purchased in that last category that you mentioned. If an approved agency or an MSA purchases a service from the Red Cross, then it falls within that definition of "service provider."

Mrs Sullivan: It says "person."

Ms Czukar: "Person" is the corporation. With respect to specific comments on the Red Cross situation, I don't know if Mr Quirt wants to add anything or not, but that's the incorporation status and the definitions in the act that apply.

There is a reason for that, I might add, and that is that with federal corporations the province can't impose requirements regarding consumer participation and so on on boards of federally incorporated bodies. That's why we require provincial incorporation, so that we can ensure that there will be significant consumer participation and that locally based and elected MSAs will not be subject to the decisions of boards of governors over which we have no control.

Mrs Sullivan: I find it absolutely extraordinary that one of the most heavily involved organizations in the entire world, including in our own community, is Red Cross, with the highest number of volunteers of any organization that I can think of, involved in so many aspects of care delivery, and Red Cross is precluded from even putting itself forward for consideration by a district health council as an MSA. In fact, the services that will be purchased, that the Red Cross is so well known for and so highly respected for in our communities, the amount of those services that will now be available for purchase from the Red Cross will be limited to 20%, if the MSA doesn't provide those services. That doesn't

provide a critical mass to keep the Red Cross in business. In Ontario we will have the only place in Canada where the Red Cross has no place in long-term care and home care services. This is nuts.

The Acting Chair: I want to allow Mr Wilson time for one short, sharp question.

Mr Jim Wilson: I appreciate that, Mr Chairman. Mr Morton and Ms Bell, thank you very much for coming down again before the social development committee, because I know in the past you've been here on other pieces of legislation. I should tell committee members that Mr Morton is not only president of the Ontario division of the Canadian Red Cross but he's also chair of the district health council in Simcoe county and administrator of one of our homes for the aged. He knows of what he speaks and is a frequent and very valued adviser to the four MPPs in the county. I want to thank you publicly for that, Bob.

I'll make it a two-part question. One is that in your remarks I think you almost begged the question, and that is an opportunity to explain the difference between enabling and prescriptive legislation and perhaps an example of where prescriptive legislation leads to ludicrous situations. I'd like you to share your thoughts on that topic with the committee, because I notice two of your recommendations actually use the word "enable."

Secondly, following along, I guess, what Mrs Sullivan has been talking about, it's very, very important that you have the opportunity right now to respond to comments that were made by Dan Stapleton this morning, for example, of the Ontario Community Support Association, one of the groups that we're told by Mr Quirt was extremely influential in convincing this government that MSAs should not only be one point of access but should also deliver the services, which as you know is the twist the government has put on this that's problematic.

Mr Stapleton said that he does not believe that people volunteer because of the history and unique identity of the organization that they decide to volunteer for. In other words, he dismisses the 75-year history of the Red Cross in terms of people volunteering for it—

Mr O'Connor: You put a lot of words in his mouth, Jim.

Mr Jim Wilson: I wrote it down as he said it.

Mr O'Connor: You're stretching it.

Mr Jim Wilson: —and the unique identity that it has in people's minds in the community. So if you could comment on both of those, please.

1440

Mr Morton: I'll try and be brief. On the first issue, the issue of enabling, we seem to be creating legislation of late that really puts handcuffs on communities and how they deliver service. I was absolutely struck—I was talking with the district health council in west Parry Sound yesterday. They were describing to me a situation that arose out of Bill 101, which in and of itself is a prescriptive piece of legislation. The requirement is that each district establish a placement coordination service.

You should know that in west Parry Sound there is one long-term care facility with 103 beds. There are a couple

of hospitals, but they're in one community: One of them is a chronic care hospital, the other is an acute hospital. So there are really only two facilities. That jurisdiction was required to establish a new office, a new placement coordination service, hire new staff to place people in the one facility that is there.

Now, granted there may be some benefit in helping people be placed outside of the jurisdiction, but I have to believe that if we had legislation that was more enabling, that gave a little bit more power to the existing players within the system, that improved communication, we could achieve a better result without having—because we have provincial legislation that says, "Every jurisdiction will have a placement coordination service"—we wouldn't have the problem that's developed in west Parry Sound. That's the point that I would make, one example, and there are others that I would use to illustrate "enabling" versus "prescriptive." We still need the service. There are better ways or different ways of doing it, ways that are more community-based.

The next question deals with symbols. The red cross and the red crescent are singularly probably the most visible symbols in the world for humanitarian organizations. Why did I volunteer for the Red Cross? I guess I volunteered because I was interested in a particular program stream, but because of what that organization stood for. While there are many people who will volunteer for whatever reason they have, I believe that the opportunity to volunteer for an organization that has a profile and a history, that has a record of service to our communities, that goes through generations, through a couple of wars, is something that we just can't say goodbye to in Ontario. I know Dan and I would take him to task for his suggestion that the symbols are meaningless these days.

The Acting Chair: Thank you very much. I wish we could carry on, but time does not permit.

AIDS ACTION NOW

The Acting Chair: Our next presenters will make a presentation on behalf of AIDS Action Now. Welcome to the committee. Please make yourselves comfortable and please introduce yourselves.

Ms Darien Taylor: On my right is Brent Southin and my name is Darien Taylor. We're both from AIDS Action Now, which is the community-based activist group which fights for equitable access to high-quality treatment and care for people living with HIV and AIDS.

Brent is a member of the provincial committee of AIDS Action Now, a social worker by training and was a counsellor at the AIDS Committee of Ottawa. I am currently a member of the steering committee of AIDS Action Now. I was formerly a co-chair of AIDS Action Now. I'm one of the founders of Voices of Positive Women, which is an organization for women living with HIV and AIDS, and I'm currently a board member of the Community AIDS Treatment Information Exchange.

Like the elderly, people with disabilities and other people with special needs, people living with HIV and AIDS are vitally interested in the current restructuring of the long-term care system in Ontario. We have long

supported the overall goals of the long-term care reforms.

The development of a comprehensive network of community-based care and support services has the potential to more efficiently deliver the wide range of services which are needed by people living with HIV and AIDS; to provide more flexible and responsive levels and forms of care than are currently available; to facilitate a higher quality and more independent life for people living with HIV and AIDS in their own homes and their own communities; and, finally, to prevent unnecessary and expensive hospitalization.

To achieve this potential, home-based and community-based support services for people living with HIV and AIDS must be comprehensive, ensuring that the full array of health, psychosocial, domestic, social and other support services are available to meet our diverse and changing needs; flexible, that is, able to quickly respond to changing needs as the health of people living with HIV and AIDS fluctuates; and, finally, well integrated and well planned. At a community level, this means ensuring that services are well coordinated, that service providers are linked up with one another and that the full range of necessary services is equitably available to all who need them. At the individual level, the goal must be to empower people living with HIV and AIDS to be able to plan and manage their own support services.

Will the proposed reforms be able to achieve this potential? There are troubling indications that they may not be able to.

First of all, although there has been extensive and laudable consultation with other providers and consumers, there's been relatively little contact with the community of people living with HIV and AIDS. There also appears to be limited understanding within the government of the ways in which the natural history of HIV and AIDS and the rapidly changing treatments for this disease have significant implications for the kind of long-term care that we need.

Unlike many other consumers of long-term care services, the range of support and the intensity of care required by people living with HIV and AIDS typically fluctuates a great deal over the course of our individual illnesses.

Improved treatments have brought to us greater potential to live longer with higher-quality lives. This in turn has led to increasing numbers of people living with HIV and AIDS needing various levels of health care and assistance with daily living.

An increasing range of medical treatments and monitoring currently provided in hospital settings can effectively be provided in community or home settings.

In fact, it would appear that the only time that people living with HIV and AIDS have been mentioned in the ministry's various policy documents was in the August 1993 draft paper entitled *Community-Based Services Provided by Multi-Service Agencies*, and only here as people at the terminal stage of our illnesses.

Secondly, we have a number of significant concerns with the legislation's ability to ensure that access to care is equitable; that there is a full continuum of vital

services made available; that the planned agencies will be able to respond quickly and effectively to the changing needs of people living with HIV and AIDS; that the restructured service delivery system can be effective while retaining the unique experience and perspectives of community-based groups; and, finally, that planning and resource allocation processes will be responsive and accountable to the communities they serve.

We detail these concerns and proposed changes to the legislation or government policy. Brent will begin with this.

Mr Brent Southin: I'm just going to put some background and people can read the recommendations that we give on their own.

As far as equitable access to care is concerned, we think the fundamental goals of these reforms and of the long-term care system must be equitable access to the full continuum of the services across the province. We are concerned with an apparent slippage in the language used to articulate the guiding principles of the reforms. The government's initial Redirection of Long-Term Care and Support Services in Ontario consultation paper was very clear that equitable access was a fundamental principle. However, by the 1993 Partnerships in Long-Term Care documents and the compendium to Bill 173 the government seemed simply to be talking about the availability of a specified range of services. Section 1(e) mentions promoting equitable access, but only through "consistent eligibility criteria and uniform rules and procedures." More effective administration is fine, but far more important is a serious government commitment to providing the resources and investment needed to ensure adequate levels of services.

A pervasive theme in this, and indeed in all current government reform initiatives, is the drive to cut costs. The compendium extols the advantages of using lower-cost workers rather than professionals for various services. There certainly are tasks for which less specialized personnel are more appropriate, but the restructuring of health care delivery has to be very carefully planned. Any redivision of labour must be done with extensive consultation with the workers involved and the unions that represent them, not by government fiat.

1450

Similarly, the primary goal of any restructuring must be delivering the highest-quality and most responsive care, not just cost cutting. The only way this can be assured is to involve consumers in planning, something the government and local DHCs have not yet done. Were consumers to be involved, one factor we would emphasize would be that continuity of care must not be lost in the search for the lowest labour costs. The possibility of having to deal with dozens of different workers because they are cheaper replicates the fragmentation of the current system. We make some recommendations on that.

The system must have a comprehensive continuum of services. We are pleased to see that a continuum of care is one of the guiding principles of Bill 173. The problem here again is that the bill gives no sense of how this principle can be put into practice. A continuum of care

means far more than the abstract list of services in the bill; it requires integrated and individualized packages of services which cover all individuals' care needs. How will the continuum of care required by consumers be identified? The only way is through consulting with people living with AIDS and HIV themselves on what they need, and with the front-line HIV service providers.

We have emphasized the broad range of services that people living with AIDS and HIV may need at different times and in different combinations throughout their illness. While the list in Bill 173 is fairly comprehensive, what if a particular service is not on it? Because additional services have to be approved by the minister, the system is cumbersome and slow at best. More ominously, the minister may refuse to recognize specific intensive care needs of people such as those living with HIV and AIDS, especially when they are expensive. If you think such concerns are overstated, remember that this is a government that has refused to put vital HIV-AIDS treatment drugs on the Ontario drug benefit program purely for cost reasons.

There is also a danger that the list of mandated services will come to be seen not as a minimum standard of what must be available but as a ceiling beyond which providers don't have to worry. Subsequent governments may use this power to list mandated services to cut costs or to create a two-tiered system of very basic mandated services, with more extensive services available commercially for those who can afford to purchase them.

The core services listed in Bill 173 are too general. For example, within the category of nursing services there is nothing to say that specialized services such as IV therapy in the home must be available to all people living with AIDS and HIV who need them. Similarly, the overall lists of services identified by the ministry may not be equally relevant in all communities or for all groups of consumers.

Can the MSAs deliver? Multiservice agencies are going to be the key means of delivering services. However, there is nothing in the legislation to indicate exactly how they will work. How will the number of MSAs needed in an area be established? What communities will they serve? Presumably this, and so many other facets of the long-term care reforms, will be worked out by the DHC and ministry planners.

We have a number of immediate concerns.

The government sees the proposed scheme as much more flexible than the current system. The policy framework paper in the Partnerships series notes that the existing maximum number of hours of service will be replaced by a dollar maximum for some services. However, there's no indication of which services or how much the maximum will be. A restrictive maximum could be a disaster for people who need intensive care for a period of time, such as those with AIDS.

The ministry intends to limit the proportion of services that an MSA may purchase, as opposed to directly providing, to 20%. Will this be a limitation on the scope and flexibility of service delivery? For example, MSAs with small HIV-positive populations may need to purchase specialized services. What if their 20% quota has

been reached already? Would having to purchase intensive, and possibly expensive, services for people living with AIDS-HIV at advanced stages of illness reduce the availability of outside services for people with other pressing conditions? Or would they simply put such people with AIDS on waiting lists? Intolerable for people whose condition has deteriorated sharply.

The September 1993 Guidelines for the Establishment of Multi-Service Agencies would allow the purchase of 10% of services from commercial agencies. This does not seem to be mentioned in the current compendium. Has this option or restriction disappeared? We support the principle of publicly funded provision of health care and social services and we believe that profit imperatives tend to have adverse effects on the quality of care. None the less, there are areas in which the commercial agencies are excellent and sometimes the only providers of essential services such as palliative care for people living with AIDS and HIV.

The standard response is that commercial provision must be a spur for public providers to improve their services. We hope this will be the case, but in an era of severe cutbacks it is hard to be optimistic. Until it can be demonstrated that the public providers can ensure that the full continuum of care of people with AIDS is flexible and adequately available, then there must still be the option of using commercial agencies. MSAs can of course work to reduce the reliance on commercial providers, but arbitrary restriction must not harm the quality and flexibility of the services they can provide.

The system must be responsive. Eligibility and service planning must be geared to changing functional needs rather than rigid criteria, and amount of care allowed, agency jurisdictions etc must not be allowed to block access to needed programs or restrict the range of services provided. Unfortunately, none of this is clear in the legislation.

The confusion is particularly worrisome for people with AIDS. Over and above the need for chronic support, needs often fluctuate quickly and dramatically. This means that services have to be immediately available when needed and that providers have to be able to quickly restructure the care plan of a person living with AIDS or HIV when their condition changes. There can be no waiting list for vital services such as oxygen, IV therapy, specialized nursing, palliative care etc. If such services are not available as they are needed, it is too late.

Unfortunately, the government seems to accept that waiting lists will continue. But even then the bill gives no sense of how these waiting lists are to be prioritized. A person with end-stage kidney disease waiting for home dialysis or a person living with AIDS or HIV who needs IV drug therapy to prevent blindness are in very different situations from those waiting for friendly visiting. This of course is not to belittle the value of the latter type of service, but there needs to be a prioritization of those waiting in terms of medical urgency of their condition and the consequences to the consumer of delay.

Then we have a number of recommendations that you can read.

Consolidation of services: As in so many areas, how the government plans to consolidate service provision and agencies is not at all clear. How will agencies be consolidated into MSAs? How many? Who will decide?

We see the potential of simplifying access points and procedures and of increasing economies of scale and improved effectiveness, but unfortunately this direction is being driven primarily by cost pressures, not by the goal of improving services and support. How will the MSAs guarantee that they can retain, and indeed improve, the quality of care and responsiveness previously provided by community groups?

If all agencies are to be collapsed into MSAs, does this mean that the services will be subsumed to the lowest common denominator; that is, the types of chronic care services typically needed by the elderly? Will the more complex or unique needs of others suffer as a result?

For example, people living with AIDS-HIV have not generally had access to nursing homes and other long-term care facilities. Has this reflected prejudice or discrimination, insufficient resources or unwillingness on the part of some providers to deal with the needs of the people living with AIDS and HIV? Would there not be a danger of such problems of inability, unwillingness or discrimination also occurring in MSAs, especially in areas with small numbers of people living with AIDS and HIV?

This has been quite clear, as the majority of people with AIDS are still gay men and it was quite clear about the Legislature the hate towards that group of people. Government-legislated agencies, we feel, would not indeed take that into account. There's been a lot of work done with current community-based agencies and the home care program to reduce that discrimination, but we are quite worried that in a new set of circumstances that will have to start all over.

We're also worried about the funding envelopes. There's a recurrent problem with Bill 173: Much of its impact will not be clear until the regulations are drafted. There's no indication of how the funds will be allocated or how priorities will be established by MSAs and DHCs.

What will happen when the envelope runs out? Will this agency no longer be able to provide services? Will certain people be denied? What's going to happen? It's not clear to us.

We want these MSAs to be accountable. We believe that 50% of all the board should be consumers—a minimum. We're hearing in the committee that one third might be, but it's not in the legislation and we do not trust the government to ensure that.

1500

We have a recommendation that you might want to try: a specialized MSA for people with HIV and AIDS. In an area like Metro Toronto, there's a large number of people with HIV, approximately 8,000 who know at the moment.

The agency must offer a comprehensive array of services, both onsite and coordinated out of the agency. A full continuum of services must be equitably available to all who need them.

We believe that this could work as a way across Metro

to ensure that people living with AIDS in Metro have the specialized care they need. We don't believe that—this isn't out of the paper—people can be ensured the services in local MSAs throughout Toronto. We don't believe that the funds will be there to have the specialized care needed.

Finally, I just want to conclude with the fact that we have a long history of a lack of health care for people living with AIDS and HIV in this province. We have had some improvements in the past few years, but we believe that if the specific needs of people living with HIV and AIDS are not taken into the MSAs, we will be back to stage 1, where we were 10 years ago when the disease started.

We have a prime example of the type of hatred that people living with AIDS and HIV have had forced on them in the health establishment by a number of health care providers and by the government bureaucracy, and we will not allow this to happen again. I take it that when this goes back for amendments, people will make sure that they have listened to people living with HIV and AIDS.

Mr O'Connor: I appreciate you coming before the committee and bringing your thoughts forward. I think there are times when we forget that the focus here needs to be on the consumer. Quite often, it's easier for us to focus on the service and the providers of the service and not on the needs of the consumer, the person who requires the service, and that they be met.

There are a number of areas that you have pointed to and I just thought maybe I'd like to go through some of them and point out what I think might be misconceptions or misunderstandings.

First of all, overall there has been a huge increase in spending by this government into the community side of long-term care. There's been a 54% increase. This year's amount of funding will be \$850 million. Since 1991, when it was \$550 million, that's quite an increase—54%. There is the intention to continue to meet the need and to put the dollars where that need is. Earlier on in your brief you had mentioned some of the problems you felt there.

Access to services: I think one of the important things that should be looked at is that we're not trying to develop something that prescribes everything that's going to happen as far as the delivery of service in certain locals throughout the province is concerned. We want to leave that planning to the local community so that the needs of the people living in that community—we're hearing people say that it's a cookie cutter approach. We don't want to get that.

What we want to see happen is that the needs be developed within the community and that they work with the district health council and the envelope funding, and the funding that will be needed for the services in the future will be directed from the district health council level so that we can see that those needs are met and that they continue to be met.

The basket of services, for lack of a better word—and you mentioned on page 4 the whole basket of services—is not meant to be an exclusive list. I think the problem

that we have in legislation is that when we start to try to define every type of service that needs to be met, if we try to be as exclusive as we possibly can, then we end up excluding things. We're not trying to exclude a service that should be provided in any given community. What we're trying to do is create a minimum basket so that the minimum needs of a community are met. Not all communities have all those needs met today. We're trying to give them a basis of where to start from, and then the community will develop and evolve other areas. To do that without naming everything, we're going to have to limit some of what we put in there. The more you put into that list, the possibility of leaving something out becomes greater. I don't know; it's an unfortunate way and I guess that makes it rather difficult.

The Acting Chair: Mr O'Connor, you may want to allow the witnesses time to comment before I move on to Mrs Sullivan, because time is running here.

Mr Southin: The only comment I have about local MSAs, local DHCs deciding what's appropriate for their community is that in a number of areas there's a massive amount of discrimination against people living with AIDS. I believe if it's not in the legislation that certain services have to be provided, people living with AIDS will not receive them.

Mrs Sullivan: You raise a number of quite key and interesting points in your brief, and I think that we're all going to want to refer to it after as well. Two of the things that strike me immediately are, firstly, that the only guarantees in terms of people who will be receiving care that are included in the act are that the care will be provided (a) in as timely a fashion as possible and (b) that the people will be put on a waiting list. Those are the guarantees.

The rights that are included in the rights section of the bill are rights associated more with the method of approach to the patient—that the patient will be treated with dignity and respect and courtesy, that the patient will have a right to information about service providers and so on.

I think that the issues you've raised with respect to the timeliness of services for AIDS patients are key, particularly where an MSA may not be able to provide those services and may have to cross borders.

Earlier in the week we had a presentation from the Baycrest Centre for Geriatric Care. Our party will be putting forward amendments with respect to satellite offices of MSAs to address cultural, ethnic and religious scenarios.

We are certainly going to want to think about some of the issues that you have raised that affect a disease-specific environment or a specialized care requirement. We will certainly work on amendments to that effect that we would like to present. I hope you will provide us with your advice on doing that. I don't have questions to ask, but I just wanted to provide notice that we'll be coming back to you for further advice.

Ms Taylor: The notion of community is partly where you get at this question. My understanding is that it's very geographically defined here and that by looking at

other communities that you've suggested—cultural, ethnocultural, communities related by disease—you can begin to get at that.

Mr Jim Wilson: Mr Chairman, I know you don't want me to ask a question, because you're out of time, but if I could just comment, because I think Mrs Sullivan has hit on something that Mr Sterling and I were talking about during the presentation, and that is that you can't afford to be on waiting lists, what about a separate MSA, in this case disease-specific?

Ms Taylor: Disease-specific. We have proposals ready.

Mr Jim Wilson: We could work on amendments to that.

The Acting Chair: Thank you very much for a very interesting presentation.

1510

CANADIAN ASSOCIATION OF RETIRED PERSONS

The Acting Chair: Our next presentation will be made on behalf of the Canadian Association of Retired Persons. Welcome. Please give us your name before beginning with your presentation.

Mrs Lillian Morgenthau: Speaking is always such thirsty business. I think that the clerk was kind enough to do a copy of this brief.

The Acting Chair: Yes, members have been provided with a copy.

Mrs Morgenthau: So everybody can follow along as I carry on.

The Canadian Association of Retired Persons is a non-profit association open to all Canadians aged 50 and over, retired or not. Our membership is coast to coast and numbers close to 180,000 people, 90,000 of whom are in the Ontario part of Canada. In addition to making financial benefits available to members through various benefits, travel, insurance and other options, we act as advocates for mature Canadians before government and non-government bodies.

We have worked diligently to safeguard and promote the health and wellbeing of Canadians over the age of 50. We've been involved in numerous discussions with government and non-government agencies, in the areas of economic security, health care, drug availability, housing and related issues on behalf of our members.

CARP was one of the first to recognize the need to keep seniors in their homes with support services as long as possible. This would allow seniors to maintain their independence in their own homes. If needed, regular assistance in the home is, in our view, far superior to putting them into an institution. The consumer responds better and the cost is far less. If a move to a seniors' establishment becomes necessary, the wishes of the senior as to type, location, cultural resources etc should be paramount. Just as one type of accommodation will not suit every young person, older people in need of care should be allowed the same flexibility to choose where they live, within acceptable cost limits.

We are concerned that the human needs facing us not be subjugated to the preconceived need for efficiency and

cost subject to consultation with family and physician. We feel that the consultation of family and the physician are not really spelled out in this particular Bill 173.

If MSAs are established, we ask that their role be specifically limited to the provision of all of the information seniors might need to make their own judgements about their ongoing care.

It is our understanding that this bill originally was to be a bill where information would be given and the consumers would have the choice of where or what or how they would go on in their lives. Since the inception of this bill, it has been broadened to many, many other areas, and we're not in accordance with all the things that are being put into this bill.

Over the past several years a great deal of thought and effort has gone into reforming the organization and delivery of long-term care in Ontario. Bill 173, in its first reading, forms part of this work.

Let's examine some of the underlying assumptions of the reform. An ever-expanding proportion of the population reaches age 65. We have over three million Canadians who are over the age of 65. Planning now has to anticipate the arrival at the battered gates of the system of the parents of the baby-boomers, followed soon thereafter by the boomers themselves. There are 7.1 million people soon to approach the age of 50; over three million are over the age of 50 already. Although far healthier than any generation before them, this age wave carries with it the effects of long-term survival of chronic but carefully managed illnesses and conditions, as well as the emergence of diseases which are not caused by aging but are seen more commonly in the elderly: chronic lung and heart ailments, mobility disorders and many others.

The capacity of families to care for their aging parents is being stretched to the limit, entire cultures and traditions are being tested for respect of the old and the willingness to endure hardships in looking after members of families who are ever more frail and vulnerable, while the care givers themselves are confronting middle age and domestic stress and discord. This group is commonly called the "sandwich" generation, and rightly so.

Unspoken but easily recognized are agendas of institutions, professional pride and turf battles, as well as fundamental beliefs about the proper role of the state in matters of personal choices, autonomy, beneficence, dependence and self-reliance.

The structures proposed here are by nature legalistic, dealing with the awesome powers of the minister, agencies and multiservice agencies. A little power is a dangerous thing; a lot of power becomes more dangerous. Implicit in all of this is a centralized model which strongly believes that all elderly clients, consumers or persons are constantly in danger of being victimized by unscrupulous for-profit service providers unless a benevolent case manager looks out for them. Accordingly, each of these seniors and disabled adults needs a plan of service without which they would go astray in the maze of competing organizations.

"One-stop access" is another buzzword, implying that without it seniors and their hapless care givers would not

know what to do. Oddly enough, the same seniors managed to figure out the Income Tax Act, the stock market, even the ins and outs of a mortgage. What one-stop access will create in this scheme is at least one more layer of bureaucracy, of which we have too much already. One out of every four Canadians work for the government. We can't really afford to have more than that. We can't even afford that, and the taxpayers are not willing to pay for it. Our present fiscal position has made it clear that we no longer can afford additional layers of bureaucracy. Our citizens have made it clear that we are no longer prepared to pay for additional layers of bureaucracy.

One aspect of the proposed legislation that is certain to boost costs is the intentional attack on private sector providers. It is doubtful that the average Ontario senior wishes to endorse a monolithic bureaucracy, having witnessed the collapse of such structures in central and eastern Europe in the past five years. Such moves do not reflect any mandate from the electorate.

This organization, CARP, agrees with the principle of dividing services into four categories listed in the act. Some areas tend to overlap, and this is far from being undesirable, but they could present economies for the system. For example, if personal care services were provided in the setting of an adult day program, these resources could be used more efficiently. If a senior attending a day program could get a bath and even toenails trimmed, this would surely be cheaper than sending out someone to the senior's home to do the same thing. Probably you'd have to send two people, because anyone doing toenails won't give them a bath. So here we are with two going when one service could be done at a simple place.

A puzzling part of the divisions created is the separation of the homemaking services from personal hygiene when in fact the independent homemaking program, a highly effective means of offloading home care cases, was based on this premise. The same homemaker who is authorized to change diapers under the heading of caring for children would not be allowed to do so for a senior who has chronic incontinence. Similarly, routine personal activities of living can easily encompass virtually all of the items on the homemaking list, yet it is under personal support services. These designations have major funding implications, as we will later find out.

1520

Conspicuously absent in the entire plan is the family physician who has established a long-term relationship with both the senior and the family. Assessment functions appear to be limited to the person's needs, implying that without proper medical diagnosis and treatment of the multitude of conditions afflicting the old the MSA can determine the true need pattern. For example, an older individual may have a problem with incontinence, without finding out the cause and treating anything from a bladder infection, constipation, a mobility disorder ranging from arthritis to a broken hip, an antihistamine-induced drowsiness or a brain tumour. An MSA delivering adult incontinence products and a nurse to apply them would end up wasting resources by throwing services at

a person rather than finding a solution to the problem. Without the medical diagnostic and treatment effort, the same person may even end up in a long-term facility, using even more resources and living in a place not to their liking.

It is this organization's opinion that as currently envisaged MSAs would represent an additional level of administration and bureaucracy. We do not believe that MSAs should be both the administrators of the system and the service providers. This would give MSAs an effective monopoly, which is not in the interests of the citizens who may require services. Our concern is that an unhappy senior citizen will neither be able to change to another service provider nor effectively complain about the services rendered by an MSA. If the MSA is the only service provider, people will require a great deal of courage to complain to them about the quality of their service.

Although the concept of accountability is crucial, the phrase "competence, honesty, integrity and concern for the health, safety and wellbeing of the persons receiving the service" may well create demands on any organization, placing the burden of proof on them, documentation and generation of spurious information adding to the flurry of paper activity and enlarging administrative overheads. If our math doesn't fail us, such costs may well represent up to 20% of the agencies' budget.

We are not certain from reading the act what the difference is between an "agency" and an "approved agency," but judging from wording one suspects that the agenda of eliminating for-profit organizations from the field surfaces yet again, infringing on the availability of choice for consumers. As previously stated, some of the distinctions between chargeable services—those listed under the community and homemaking heading—and non-chargeable items—under personal and professional support services—may well be artificial and costly. Imaginative matching of needs through multiskilling and multitasking would be inhibited, flexibility of service providers reduced and, in a worst-case scenario, actual turf wars may erupt; eg, one cuts toenails but not fingernails. This is today because the chiropodists are currently instructed that they cannot cut fingernails as well as toenails. I mean, it's unbelievable.

Most importantly, competition must cease to be a dirty word if we want the system to deliver more bang for the loonie.

CARP feels that any person asking for help or information would find the MSAs would respond with literally, "My way or wait in line," and would not give options and alternatives in the private sector. This is unsatisfactory in every way. All options must be presented and the choice made by the senior, his doctor or his family.

This organization strongly supports the concept of aging in place, delivering services to seniors instead of warehousing them for the convenience of the system. The flip side of the coin needs to be kept in mind as well: There must be sufficient room in the long-term facilities, with appropriate staffing and funding, so that they are

available before an untenable care-giving situation victimizes the women currently looking after the frail elderly to the point that daughters are forced to choose between marital breakdown or admitting their ailing relative to a facility.

We all know about the people who are caught in that. I don't think there is one person in this room who doesn't know of a family that has been caught in that particular situation. It can be devastating to a young family and to an older family. I think this is one thing we should really look at very seriously. These reforms are long on regulations and policies but, so far, short on caring and compassion.

A major corollary to aging in place is a future planning and funding implication that by keeping the elderly in a community longer their care needs and requirements will be higher when and if they finally enter long-term care facilities. Their medical state will also be more precarious and therefore they will need more monitoring from the attendant physician looking after them in the nursing homes and homes for the aged.

Current funding levels are becoming woefully inadequate, and the level of stress experienced by health care professionals does not bode well for our preparedness to properly look after the frail elderly.

No government in Canada would wish to be blamed for causing suffering to helpless thousands and even for the untimely demise of those so far cared for so well. The effective downfunding of long-term care facilities under the phony slogan of equity must end.

In order to guarantee appropriate assessments of seniors asking for service, heightened emphasis needs to be placed on geriatric medical consultations with the express goal of identifying treatable causes of disability, followed by interventions to maximize seniors' function through rehabilitation. This concept is missing from all foundation documents, yet the greatest efficiencies could only result from achieving and maintaining the general health of the current and future generations of seniors.

CARP proposes a system that is less bureaucratic and monolithic, allowing seniors and their families to obtain advice but without losing the right to choose how they wish to live, whom they wish to entrust with their care and freedom to determine their own future. There is a need for a much smaller endeavour that assists those who can't advocate for themselves, those the act designates as "apparently incapable persons." However, in those circumstances the concept of autonomy must be balanced by that of compassion, a goal unfortunately not achieved in the Substitute Decisions Act of 1992.

1530

The elimination of many service providers, such as the Victorian Order of Nurses, Meals on Wheels and the Red Cross—those are the kinds of organizations that we have to look at—and many others will result in a loss of service of many of the volunteers who make these services possible. We would like the assurance that the existing volunteer base be preserved, for without it service will not be delivered. The expertise in delivery of service built up over many years, the intimate cultural

knowledge of providers must not be lost in a restructuring of the system.

We do not understand why this government, which has insisted on giving disabled people the opportunity to choose from a variety of services for their care, should insist that older people may not choose from the options available for their care.

We have heard horror stories about elderly people being sent home from hospital without adequate care. We are fearful that there may be dangerous gaps in service in any changeover from one system to another.

We urge you to welcome the "inside" information and suggestions offered by those who now or will before too long be consumers of the services under discussion or who have been dealing with the problems as they exist today.

I thank you for the opportunity to appear before these hearings. We would be happy to continue the dialogue established at this forum and will be available for future and further consultation.

The Acting Chair: Thank you very much. We have about 10 minutes for questions. Each of the parties wishes to place a question. We'll start with Mrs Carter.

Mr Jim Wilson: Mr Chairman, wouldn't it be my turn? I didn't really get a question last time.

The Acting Chair: No, I'll stay with Mrs Carter.

Mrs Morgenthau: You're in tough shape.

Ms Carter: Well, we missed one round. Thank you. I certainly agree strongly with you that the objective is to keep people at home so that they can age in place. That is one of the objectives of the act. Certainly, it is an objective of the act too that the person's needs and preferences are of the greatest importance. In other words, nothing is going to be forced on to a consumer.

But I have to say that I think on page 4 of your presentation there are quite a few misapprehensions. You say that the structures proposed here are "legalistic," "a centralized model," and that somehow people are going to be taken over by administration. I think that's very far from what we're actually proposing here. The organization is going to be localized and it's going to be community-driven. It is not a bureaucracy. We're not imposing bureaucracy here. If anything, we're doing away with it. For example, in Metro at the moment there's only one big organization that deals with home care. Under the proposed multiservice agencies, there would be 15 to 20, so we're not making it more massive, we're breaking it down.

Mrs Morgenthau: That is probably the concept that we're fantasizing. In reality and in practicality, that will not occur. Let's take the MSAs; I think there are about 12 of them proposed for Toronto alone. At this point in time, when there is a chronic care patient, say, at a hospital and they want to get a chronic bed outside the hospital because the hospital is not prepared, really, to take care of chronic care patients, there is usually one person whose duty it is to find a bed. When you have one central area to which you now have to go, from hospital, from home, from anywhere else and find a bed for a patient—we do not have that kind of facility.

Our feeling is that the cart has been put before the horse, that we're not ready for this kind of Bill 173 and that we should be doing more to get ready before the MSAs. If you phone the MSAs and say you need a bed, they'll say, "Fine, where do you want it?" and they will try. But at this point, if there isn't a bed available, they will not say: "You have other options. There are not-for-profit organizations. Would you like to try some other area?" It's either that or get in line, and it's going to be a long line.

The Acting Chair: Thank you. We'll move on to Mrs Sullivan, please.

Mrs Sullivan: Thank you very much. With respect to your brief—

Mrs Morgenthau: Why don't you let Mr Wilson handle it? The poor guy's been trying for hours to get in.

Mrs Sullivan: I'm not going to let him on.

Mr Jim Wilson: I'm looking for a sympathy vote.

Mrs Morgenthau: Are you bowing to the lady?

Mrs Sullivan: I have the right of the Chair to speak.

First of all, we concur that a clinical assessment of the medical and other physical needs of the person who's involved in long-term care is absolutely required. Certainly the evidence that's before the committee has been that about 90% of individuals who seek some long-term care services have an acute or a chronic trace with respect to the need for those services. So the medical intervention that you've talked about, the medical assessment, we see as very much a part of that. Whether that's coordinated through the MSA or whether there is a working relationship with the family doctor, we feel it is very much a part.

You have mentioned, as have a couple of other groups, the difficulties with the separation of those services for which there will be fees and those services for which there won't be fees.

One of the other groups indicated to the committee that it felt that the individual who was receiving the services was going to have an additional burden of accounting for the kinds of services that were offered because they may well be offered by the same individual. One person, for instance, may provide personal care such as bathing and assistance with dressing but may also be doing other things with the individual who's receiving the care, with the client.

How do you think that those fees are going to be tracked, and is it kind of a nimble myth anyhow that the chargebacks will be accurate? Because there are chargebacks for basically non-health-related services that are accounted for in this bill.

Mrs Morgenthau: How are they done now, Barbara?

Mrs Sullivan: Well, you see, they're delivered by quite separate vehicles.

Mrs Morgenthau: Perhaps we need those vehicles. If we continue with this and the MSAs are going to take on and absorb, say, Meals on Wheels and everything else that is already in place and well done, very well done, taken over by an administration that has really got to learn how to do this kind of thing, we're going to find

that many, many seniors are going to be left at the gate.

The thing that bothers us very much is that, especially with seniors, they know certain organizations and certain community groupings, such as the Red Cross, the VON, the Meals on Wheels, have a lot of things in place already that they know about. If they get absorbed with the MSA, they won't know how to get there.

The MSAs as well, as far as we were concerned, were supposed to be an area of information, telling people how to get what they want, where it's available and to help them get it, but not to be the centralized area that they're talking about now where actually you're going to be at the mercy of whether or not they have a person there who can accommodate you.

My fear, and I think our fear, is that the boomers are coming up, that there are so many aged people who are going to need services. If we don't have the services out there to accommodate them, then it's going to be chaos and the money is not going to do it. We don't have enough money to accommodate them. We need to have services in place that are still there and the MSAs should have the information for it.

There is no way that an MSA is going to place a person who is in a home and has Alzheimer's and all of a sudden is in desperate need of a bed. They're not going to place someone from a hospital or some other spot as quickly or even think about it. They're going to be forced to put that person into a protective environment, whether it's a protective environment that's suitable or that isn't suitable. They can put someone from North Bay into Barrie, away from all their facilities, because there happens to be a bed there.

This is practicality and this is reality. We can have the most wonderful intentions as far as legislation is concerned, but putting it into practical ways and means is another story.

Ms Carter: But we're spending money—

Mrs Morgenthau: No, the money isn't going to do it. It's not enough; it will never be enough.

1540

The Acting Chair: Mr Wilson's been very patient. I want to give him the opportunity to round up this session of questions or to begin the next one.

Interjection.

Mrs Morgenthau: No, it'll spend more.

Ms Carter: You'll see.

Mrs Morgenthau: A difference of opinion, but our research says you're going to find the costs are going to skyrocket.

Mr Jim Wilson: Exactly on that point, Mrs Morgenthau, I want to thank you for your presentation because it's full of an abundance of common sense. I suspect that when the government tells people, retired persons such as yourselves and your organization—

Mrs Morgenthau: I'm not retired; I'm working harder now than ever.

Mr Jim Wilson: Sorry, I'm just looking at the name of your association, the Canadian Association of Retired Persons. I am reading the right brief here, am I?

Mrs Morgenthau: Yes, but that retired person is a falsity.

Mr Jim Wilson: Busier than ever.

Mrs Morgenthau: It's a falsity, let me tell you.

Mr Jim Wilson: We realize that because often in political campaigns we like to call upon retired persons and we do find out that once they retire they're busier than they ever were. They're very busy volunteering for all kinds of things.

Mrs Morgenthau: That's why we mustn't throw them out the window.

Mr Jim Wilson: Exactly, and I think we should listen to them. I think that when the government accuses you of having misapprehensions—

Mrs Morgenthau: Do you think they hired me? No, they didn't. Let me say one thing.

Mr Jim Wilson: Sure.

Mrs Morgenthau: Then you can continue.

Mr Jim Wilson: I think I'll probably—it's your presentation, Mrs Morgenthau.

Mrs Morgenthau: Look, CARP does not take any funding from the government. The views that are being expressed are very neutral and are the views of our members. We get approximately 100 letters a day. Out of these letters come the views and the opinions of people all across Canada, not only Ontario. What I'm bringing to you is not the way I think; it's the way they think.

The Acting Chair: Thank you very much. We appreciate that. A very candid presentation.

Mrs Morgenthau: I'm sorry, Mr Wilson, I cut you off. Did you want me—

The Acting Chair: Our time has elapsed, I'm sorry.

Mr Jim Wilson: A very eloquent summary, and we'll just leave it at that.

Mrs Morgenthau: My number at the office is 363-8748. You can get me any time. Anybody who's over 50 should be a member of CARP. It was a pleasure. Thank you very much for having me.

The Acting Chair: The pleasure was all ours. Thank you.

FEDERATION OF ONTARIO FACILITY LIAISON GROUPS

The Acting Chair: If I could call upon the representatives for the Federation of Ontario Facility Liaison Groups, welcome to the committee. Please make yourselves comfortable.

Mrs Janet Allingham: It will just take a second to pour a glass of water.

The Acting Chair: By all means. Before beginning, I ask that you please provide us with your names.

Ms Allingham: Janet Allingham.

Ms Margaret Gorman: Margaret Gorman.

Ms Allingham: Are we all set?

The Acting Chair: Yes, we're all set. Please begin.

Ms Allingham: Ladies and gentlemen, Margaret and I represent the Federation of Ontario Facility Liaison Groups, which is an umbrella organization of representa-

tives of parent organizations for provincial schedule I and II facilities for developmentally disabled persons.

We appreciate the opportunity to appear before this committee. Long-term care is often considered a need for the elderly. Actually, our developmentally disabled persons spend a much longer period of their lives in long-term care.

Bill 173, in part, states the intent to provide government services for people in their homes, in the community and other community settings as alternatives to institutional care. This is an area in which we have great interest. The basic options presently for our developmentally disabled people are family homes which are foster homes. This, to us, is totally unacceptable. It gives our people very little chance to have association with peer groups and is virtually impossible to monitor.

The other common option is a group home in a community setting, three to five people in a particular house in a residential area. Again, developmentally handicapped people, like the rest of us, do not necessarily choose their friends from the people with whom they are billeted. They need to be part of a larger group where they can have a true choice. Like other members of society, they need to have a choice of living opportunities.

When clients go through the trauma of leaving a provincial centre which has been their home for many years, the result should be improved living conditions, not a change of address and certainly not lesser conditions. Our people are extremely handicapped. A few statistics:

From Huronia Regional Centre, which is my home centre, 43.5% of our people have a profound degree of mental disability. Medical term? Mental retardation. Also, 35% have a severe degree. Those remaining have a similar condition to a lesser degree. Along with this are the complicating disorders that these people have: 54%, seizures; 40%, visual impairments; hearing impairments, 31%; physical disabilities, 21%; 17% have dual diagnoses. A substantial number have to be fed, some by gastrostomy.

At Rideau Regional Centre at Smiths Falls: 64.7%, profound mental retardation; 21%, severe. Thus in Rideau Regional Centre a total of 85.8% of the residents have either severe or profound mental retardation. The other complicating factors are similar to those in Orillia. These figures reflect conditions found in most other provincial centres.

When planning for the care of the developmentally disabled, we must consider the wide range of disabilities. If we were caring for people with broken bones, society would have no problem understanding that different care is required for a broken arm than for a broken back.

Our people are very vulnerable. We do hope that plans made on their behalf do give their wellbeing top priority. Parents have often been told that buildings on provincial centre lands are too expensive to operate and to modernize. A few observations:

Parents at Bluewater Centre in Goderich were very upset to learn that after it was taken over by corrections, it had to be fitted with air-conditioning before the young

offenders could move in. This was not done for the developmentally handicapped.

At Oxford Regional Centre at Woodstock, this past year I received notice that there would be one of the cottages closing a little earlier than had been anticipated, the reason being there were jobs for the staff in other sectors of society. Some of the clients would be inconvenienced. Now, I do not blame the administration at Oxford centre for this, but I do question a system that would require such a decision to have to be made.

Huron Regional Centre at Orillia: The Attorney General's office has decided to take over one of the oldest buildings 18 months earlier than was planned. This building will be gutted and refitted for the Attorney General's office. Apparently, these buildings are useful after all.

In the case of Orillia I'll have to be fair. Some of these areas have been refitted for very nice apartments for six to eight clients: special kitchens, special bathrooms, the whole bit. They're very attractive. Parents are very anxious to get their person into these new apartments.

The federation is quite aware that over the past years there have indeed been improvements made for the severely developmentally handicapped. However, unfortunately, there are those placements that have been unsuccessful when both clients and parents have suffered much grief through inadequate placement policies. We believe it is time to review what has happened, what has been successful, what has not. Plans have been under way for 20 years. The world has changed a lot in 20 years. It's now time to rethink some of our plans.

1550

Our federation has long been concerned that major plans for the severely developmentally handicapped were made without the benefit of reliable research data and test projects. I will briefly mention three such sources of information that we happen to be aware of.

In England, a research section was done at Kent University on cost-benefits and successes and failures of moving clients from institutions, or hospitals as they call them, to the community. It was initially determined in England that 10% of the clients in these hospitals could not go to the community; they couldn't cope with it. After the process was under way, they found that another 5% had to be returned to congregate care.

Next, Dr Bruce McCreary at Queen's University has done considerable research on quality of life for the developmentally handicapped. We have yet to see adequate acknowledgement of this work by the Ministry of Community and Social Services and its application to our clients.

Next, Dr Ben Goldberg, University of Western Ontario, has done an extensive study of community health issues in southwestern Ontario. Dr Goldberg's findings so adequately and clearly reflect our concerns that I have included a copy of Dr Goldberg's report at the end of this brief.

Time does not permit me to do justice to Dr Goldberg's report, but a few points: Physicians require more training in care of the developmentally handicapped;

difficulties in getting records; sexual issues; medication issues; concerns that clients cannot just assume decision-making rights without concomitant responsibility; in many areas mental health clinics do not welcome the dual-diagnosis clients—these clinics feel that the clients are being dumped on them; a need for more residential resources.

Recommendations: We feel that the policy of total deinstitutionalization should be reviewed. Any policy, no matter how good, if taken to extreme, can lose its value and in fact even become harmful. In the great push for deinstitutionalization, families in the community with aging parents have been denied placements because these placements in the community were given to clients from the centres. This has caused much grief and resentment in community parents, and institutional parents are often worried as to when their person will be put out. Services in the centre should not be lessened while there are clients there and overcrowding in the centres is unacceptable for any reason.

Next, we feel that congregate care should very seriously be considered in this bill. At the end of this brief I have some comments by a therapist, David Hingsburger, who has some very interesting and informative comments on this subject.

The advantages of congregate care for these people: They could live in campus-like cottages or apartments of four to six, those who are mobile could move about freely and safely and not always have to depend on transportation, they could have central services of needed professionals—medical, nutritional—they could choose from activities either in their own community or the general community and they could be, to some extent, protected from the stresses of the community. After all, some of these people came to the institution because they could not cope with the stresses of the general community.

Such an idea would be a bonus to the taxpayer: More economical use of specialized professionals, less transportation costs and, ladies and gentlemen, consider the cost of buying a house in the general community to house three to five persons. Then, after you've bought it, you refit it for the developmentally disabled: special kitchens, special bathrooms with lifts, ramps and, if it's got more than one storey, elevators, and individual maintenance.

Individual communities are becoming very popular. In recent years developers have been very busy providing these for seniors. They provide residential, recreational and sometimes extended health facilities. Why should this lifestyle be denied to the developmentally disabled?

Next, developmentally disabled persons often live long lives. There should definitely be geriatric and nursing home plans made for them, the same as for the general population.

Some conclusions: Our federation requests that developmentally disabled persons be protected under Bill 173 and other government long-term care initiatives. We agree that services have to be available in the community, but we also request that these services include some congregate care. Let us allow the developmentally disabled to have communities that are truly theirs, where

they can live in dignity, enjoy the pleasures they like, with the opportunity to move safely and freely about as well as benefit from professional services.

Our people are very vulnerable. They need recognition from all levels of government, especially the ministries of Citizenship, Health and MCSS.

The federation has also compiled a task force report on the study of future placements of residents moving from Rideau Regional Centre to Ottawa-Carleton. This report was compiled in cooperation with the federation, the Ottawa MCSS and Rideau Regional Centre. It offers a possible congregate care model. It was submitted to MCSS for consideration in December 1993. We would like to have discussion on this report. Although we have repeatedly asked for a meeting for this discussion, it is with surprise and deep disappointment I have to report to you that we are still waiting for this meeting. Hopefully it will soon be granted.

Once again, I thank this committee for the opportunity to appear here and I ask for your support for our severely developmentally disabled persons. There are some inclusions to this brief that I believe are informative and hopefully will be helpful.

Mr Gary Malkowski (York East): Thank you for your presentation. I'm sure that the information in there will help us understand the issues of the developmentally disabled, and you're right that we do need to recognize the range of residential placements right from institutions to community.

I'd just like to ask you something for clarification. The MSAs in the community, would you like to see institutional or congregate living included as one of the options under an MSA?

Ms Allingham: Yes, definitely. It is an option. People should have a choice. As Mr Hingsburger on the last of this report said, this issue is not about segregation, but about choice.

Mr Malkowski: Could you tell me the percentage of the severely developmentally disabled who are being looked after by their aging parents?

Ms Allingham: I'm sorry, I do not have that. I could get that for you, if you would like.

Mr Malkowski: Do you have any idea of what the statistics would be in Ontario of severe and profound?

Ms Allingham: The last figures that I heard on how many were, there was supposed to be approximately a waiting list of 2,500 to 3,000 people, developmentally handicapped, in their own homes in Metro.

1600

Mrs O'Neill: Thank you so much for coming. I think you continue to be a wonderful advocate on behalf of those who cannot always speak for themselves.

Ms Allingham: Thank you.

Mrs O'Neill: I particularly want to take note of the document that you mentioned, the task force document. I have read that. It is an excellent document. I think it should be tabled.

As you likely know, the lead minister in this issue, Bill 173, is the Minister of Health. I am very sorry that you

have to report that Mr Silipo has not met with you, but I think you should send this to Ms Grier because I think that anybody who is dealing with Bill 173 should read that task force report, because it is community based, it certainly has to tie in with Bill 173.

Ms Allingham: Mrs O'Neill, I have sent it Mrs Grier.

Mrs O'Neill: Good.

Ms Allingham: And to Citizenship, Education and to Mr Charlton's office.

Mrs O'Neill: I hope you will get responses, and I hope you will follow up with Ms Grier, in particular because of its relevance to Bill 173.

Although it's such a sad tale, I'm glad you have brought to the Legislature the story of the three disabled people in my riding in Nepean. I feel that was a tragedy that should have been somehow discovered. There seemed to be some people involved in it; whether an MSA under Bill 173 can do that, or would even think of doing that, or be equipped to do it, I don't know.

I wonder if you could tell me how you feel Bill 173 could be helpful to you. I think we've heard from several, and you're one of them, that choice is one of the things that seems to be in jeopardy here.

Ms Allingham: Yes.

Mrs O'Neill: If you had one or two things you could tell us about Bill 173 and how it affects those you speak for that you would put in this bill, we'd like to hear that.

Ms Allingham: I guess my first choice, and major choice, is that the bill include some form of congregate care for our developmentally disabled persons. We are not interested only in maintaining these people, but these people do socialize among themselves, and they should be able to compete. If you can't compete at your own level and you can't experience some success, life is not very pleasant. I think there has been an assumption that they want to be out in the "community." What about a community for them? Does that clarify what you are asking, Ms O'Neill?

Mrs O'Neill: Yes, and I think that what you're saying is that in the communities where the MSAs are going to be established, these congregate groups have to be considered as part of the care pattern.

Ms Allingham: Thank you very much.

The Acting Chair: We have a bit of time remaining, if Mr Sterling has a question.

Mr Sterling: I want to tell you, I'm a tremendous supporter of Marg Paproski and her group—

Ms Allingham:: There's a section in Ottawa, I think.

Mr Sterling: Yes, her group and the Rideau Regional Centre. I think it's a shame what my government did, what the Liberal government did and what this government did in the deinstitutionalization of many, many of our mentally handicapped, developmentally disadvantaged people. We have put people on the streets, washed our hands of them as a government and walked away from them. I think it's a shame that in this whole thrust towards deinstitutionalization, we have lost sight of many, many disadvantaged people like the three in Nepean, who have just fallen between the cracks. There are people

from Rideau Regional Centre who have just fallen off the face of the earth. Nobody knows where they are. They can't trace them. Presumably they have either died or somebody is taking advantage of those individuals.

What I'd like to see put forward, and perhaps maybe the Ministry of Health can put this under the MSAs, I don't know if it's possible, whether this bill is structured as such, is that every time an individual is deinstitutionalized, that the MSA becomes responsible for that individual, has the legal responsibility for that individual and that it becomes retroactive for every individual who has been deinstitutionalized from any institution in this province. Because then and only then, will we see proper care for these people, either in the community or in some cases, perhaps it will bring some sanity back to this equation and some of them will be readmitted to some of these very, very fine residences. I don't call them institutions.

Ms Allingham: Not any more.

Mr Sterling: I call them homes and residences. I want to tell you, you've got a great ally in myself—

Ms Allingham: We know.

Mr Sterling: —in terms of your stance on this issue and I only wish that more of my colleagues would pay attention to both sides of the debate in this issue.

Ms Gorman: I wish so too.

Ms Allingham: May I add one thing here? When I was president of the Huronia Regional parents' group I asked to be able to track where some of our people went. You know, I want to go and see. I am told: "Oh, we can't tell you. That's confidential information."

Mrs O'Neill: I get the same answer.

Ms Allingham: But I have frequented the streets—without giving the wrong impression—the malls and the restaurants in Barrie and Orillia, and if you listen to what's on the street, I'll tell you, you'll get a lot of stories of what's happening to these people, and, as Mr Sterling said, it's sad.

FAMILY ASSOCIATION FOR MENTAL HEALTH IN ETOBICOKE

The Acting Chair: Our next presenters are representatives of the Family Association for Mental Health in Etobicoke. Welcome to the committee. I understand that you don't have a written brief for committee members but that we'll be making copies for distribution later?

Ms Judy Wallace: Yes, I will.

The Acting Chair: All right, thank you.

Ms Wallace: I apologize for that. This unfortunately caught me at the last minute.

The Acting Chair: That's no problem. Please give us your name before beginning.

Ms Wallace: My name is Judy Wallace. I'm the coordinator of FAME, which is the Family Association for Mental Health in Etobicoke. I recognize some faces from other legislative committees. Our role in Etobicoke is to work with families in which someone experiences a serious mental illness. I would like to say thank you, first of all, for the opportunity to speak about this piece of legislation; it is very important.

As you are all aware, the care and maintenance of the elderly in our society is a growing need, especially as we all get older. However, I'd like to address my remarks to an aspect of long-term care that I feel has been left out of your consideration, that of the elderly providing care either for another senior or for adult children. I would ask if you have considered the community services and supports that would assist those senior and handicapped care givers to provide that care over as long a term as possible. Have you considered improving the quality of services so that senior and handicapped care givers' health concerns are also a factor? Are the needs and preferences of care givers regarding management and delivery of community services taken into account when planning services?

Much of this legislation is designed to delay the time that an individual will require institutional care. Maintaining the health of the care giver is one of the most important means of ensuring that longer-term community care is available. You want to encourage local community involvement in planning, coordinating, integrating, managing and delivering community services, but how and by whom? Will those needing care and those providing care in the community be partners at those planning tables?

I would hope that all sectors of the community are invited and mandated to participate, as has begun in mental health. Those who are health care professionals, paraprofessionals, elderly requiring care, families who are providing care, elderly who are providing care and other senior support services should be around any planning table.

The bill of rights in part III outlines a comprehensive set of entrenched rights for those receiving care. I would ask how those seniors and handicapped who are also providing care would be covered under this section. It's equally important that the care giver be treated with respect and courtesy, that his or her privacy be respected and his or her culture respected. Care givers also need to know who is coming into their home to perform what tasks to whom and to whom these people are accountable.

Many care givers are providing 24-hour care for a spouse or adult child. In many instances, the shifted role to care giver changes the marriage relationship. It puts the care-giver spouse in a parental role. Respect must be given to that spouse for his or her grieving over the death of that marriage.

Community support services must be sensitive to which activities the spouses wish to keep between themselves and which need the intervention of a professional. For instance, one family affiliated with FAME was facing the problems of advanced arthritis and late-onset schizophrenia in the wife. The couple had maintained a traditional marriage relationship for their ages, they were in their mid-70s, and culture, they were from southern Europe. When the wife had difficulty feeding herself, the husband, as care giver, felt it was his role to cook for and feed his wife. However, when the wife became unable to look after her personal care, neither one was comfortable having the husband provide that kind of care. Mrs C stated that in 52 years of marriage her

husband had never seen her naked, and even though she was sick and crazy, he wasn't going to see her now.

1610

Unfortunately, because Mr and Mrs C only wanted one service, no agency was prepared to provide it. Mr C was required to find someone privately to bathe, groom and dress his wife. That left him at the mercies of the marketplace with no protection from bad service. Because of the additional strain of trying to find, keep and pay for a series of personal care attendants, Mr C collapsed from nervous exhaustion and was himself hospitalized. At that juncture, Mrs C had to be placed in institutional care, a situation both husband and wife had wanted to avoid.

What would've helped? Recognition that when two seniors are involved in a care giving and receiving situation that greater flexibility and sensitivity is required. Services need to recognize the relationship between the two people and support their mutual needs.

In another instance an elderly mother, Mrs W, is providing care for her 45-year-old daughter who suffers from a serious mental illness. Because mother's handicap is visible while daughter's is not, only mother is eligible to travel on Wheel-Trans, so that the two of them are not able to go out together. A symptom of the daughter's illness is isolation so she will not go out of the house alone and her mother's unable to go with her.

So the two women are alone in a house together 24 hours a day, seven days a week. What will happen to daughter when mother is no longer able to provide care? Will all her years of devoted care produce an instant street person because she has become either institutionalized or has died?

Mrs Y has expressed concerns that there doesn't seem to be any help for her situation. At 79, she's providing care for twin daughters who have dual diagnosis of developmental delay and mental illness. She says that 40 years on her knees as a cleaning lady has given her severe arthritis. She also has difficulty with her vision and breathing. She's worried about her own health and the long-term needs of her daughters, but can't find a workable solution. What should she do?

I could go on and on with examples of care givers whose needs as elderly, disabled and ill are ignored, but I hope this makes my point.

You speak about multiservice agencies. There is an organization in south Etobicoke that is designated as a multiservice agency, LAMP. That organization has been around for nearly 20 years and is well known by the minister. There's another in the city of York, YCS. It's also been around for nearly 20 years. These two organizations were set up as pilots to see if the concept of multiservice was viable. I don't believe that any other multiservice agencies have been funded since. Has this concept been revived or is there another definition of which I'm not clear? Is there funding to create new multiservice agencies where there are currently none?

I note that municipal health units can operate as multiservice units. I believe this is an attempt to address rural and northern service needs. This proposal does create some problems. For instance, the agency that is to

provide community care also has an enforcement mandate. I believe that these two roles are incompatible. They may also prevent those in need of community support from asking for it out of fear for the enforcement component.

The board component of these designated agencies is comprehensive and laudable. However, if existing organizations are to become designated, then time must be allowed for an existing board to meet the rigorous criteria outlined in the bill. And will the same criteria apply to health departments in municipalities? Will an advisory or steering committee have to meet the same standards as a voluntary board?

As you discussed in the development of a plan of service in section 20, when an individual applies for service the agency shall assess the person's requirements, determine the person's eligibility and, if eligible, develop a plan of service.

How will this help any of the families I discussed earlier? Will Mrs C's needs be considered in isolation from those of her husband? Will this help Mrs W whose daughter's needs must be considered as well as her own? Can Mrs Y separate her own needs from those of care giver that she must perform?

It's critical and necessary to negotiate with all the relevant members of a family when providing long-term care services.

Section 22 discusses that services will not be provided without the person's consent. Although I would never want anyone to feel intruded upon with community service, I still maintain that an entire family assessment is needed to determine need. There will also be instances in which the substitute decision-maker under either Consent to Treatment Act or Substitute Decisions Act will change that clause.

In the required services, I see no mention of psychogeriatric assistance. I realize that services prescribed as professional services were intended to cover a range of supports. However, it seems that specific inclusion of psychogeriatric treatment should be included as either provided or procured.

As a small point, under subsection 29(12), surely, if a plan of service is developed respecting the bill of rights, part III, then it would involve the person from the onset, and if the relationship between agency and client is contractual, a copy of the service plan should be provided to that client and family.

A great deal of effort's been expended on ensuring that all possible changes in service delivery have been considered and planned. That is a thorough and responsible approach. I'm also pleased to see the detail outlining the client's right to sue under various conditions.

Sections 52 and 53 seem to run parallel to the Advocacy Act. Will advocates and supervisors be attempting to assist the same individuals? Who will be in charge if both are called?

Paragraph 11 of section 56 mentions the requirements of the agencies to develop and implement a plan for recruiting and using the services of volunteers. What services will volunteers perform? How will they be

accountable? What liability will the agencies have for their volunteers? What protection will volunteers have from the agency?

I have commented on a number of items contained in the long-term care bill but my overriding concerns remain on what consideration has been given to the elderly care giver in the development of this legislation. I cannot quote statistics from other fields, but in mental health, 60% of community care is provided by families. Many of those family care givers are mothers of adults, spouses or older siblings taking over from deceased or infirm parents. In one instance, the care giver was a 62-year-old woman whose mother had died, leaving her to care for her grandmother.

The burden of community care often falls on those who feel they have no options. It's important to remember those providing care as it is to support those who need the care. Remember, no matter how many services are needed in a family, it's still less costly than institutional care, which brings me to an ongoing concern. How will these multiservice agencies be funded? Where will the government find the money when millions are being stripped from the health budget to fight the deficit? What will happen if there are not additional resources to implement this bill and communities have no resources to develop the required services?

Thank you again for the opportunity to present family views on this.

Mrs O'Neill: Thank you, Ms Wallace, for coming. You've brought things in a different way or used different words than others, but you've brought some of the very same crucial problems and I'm actually going to ask legal counsel to help me get some of the answers for you.

I do think you are very correct when you say there's nothing about psychogeriatric care in this bill; at least I can't see it. So that's going to be my first question to legal counsel: Am I overlooking something or could it fit into one of the titles that I do not yet recognize? Respite care and case management, which I think you've said in a different way, are also lacking, and others have brought that to our attention. So I ask legal counsel if they can give you any guidance and direct you to parts of the bill that may attend to some of those concerns you've brought.

So if I may, Mr Chairman, ask legal counsel to attend to psychogeriatric services, case management and respite care. They seem to be omitted from the bill. Are we overlooking parts of the bill that could be interpreted to be attending to those issues?

Mr Wessenger: I'll ask legal counsel to clarify the definition.

Ms Czukar: With respect to psychogeriatric services, they're not mentioned specifically in the bill but the multiservice agencies and approved agencies would have the capacity to purchase those kinds of services in particular from specialized service centres that would provide those, and that was the intention, not to require every MSA to provide that kind of highly specialized service but to have it accessible through the MSA on a purchased basis.

Ms Wallace: I would feel more comfortable if that was more clearly stated.

Mrs O'Neill: Every MSA needs it.

Ms Czukar: I guess it's a question of allowing the flexibility on the part of the MSA, together with the family and the consumer, to be able to identify the needs and to access whatever kind of service is needed, so that rather than prescribing particular kinds of services that could be accessed, we'd leave that open so that it allows the greatest kind of flexibility.

Ms Wallace: Could I make a further comment on that? Our experience has been that people with psychiatric disabilities are not first on the list of "please come to our service."

Mrs O'Neill: Exactly.

Ms Wallace: People with psychogeriatric problems are not first on the list of seniors. Most services are happy to have seniors because they're nice, grateful, tidy people. But psychogeriatrics don't tend to fall into that category and don't tend to be real popular, and so services which can avoid this group do so with great energy.

1620

Ms Czukar: I think that Mr Quirt, the acting executive director of long-term care, might wish to add something with respect to the availability of those services and so on. I'll just answer the question with respect to case management and respite care.

The term "case management" is not used in the bill. There is a section 20 with regard to the plan of service that requires approved agencies to assess people's needs and to develop a plan of care with the participation of the person and their substitute decision-maker and anyone else they might wish to involve, and to review those needs and redesign the plan if necessary and to deliver the services that are in the plan. That's seen as a kind of operational, functional definition of case management and certainly ongoing coordination of those services and so on can be done by the MSA as part of their mandate.

With respect to respite care, that's included specifically in the definition of care giver support services, which is, as I understood your presentation, what you're most concerned about and certainly respite is a very major part of that kind of constellation of care giver support services.

Ms Wallace: Respite care is not always an issue that can be easily addressed particularly in dealing with seniors who are care givers looking after someone with mental illness, because it's very difficult to say to somebody in their mid-40s: "You're going to go on a vacation and this is where you're going to go. You're going to go to Kipling Acres for a couple of weeks with the old folks." It's a very, very difficult issue and it puts a lot of people in a very stressful situation because they have no options.

I don't have an answer to that. If I had a magic, golden answer to that I'd sure sell it, but we don't. But we do know that people need very short-term support, and case management can often be too stressful and too assertive a service for a lot of people. What they need is

just two or three hours off to go to the bank or go to the hairdresser, go out for a coffee or, heavens, go to the grocery store.

Ms Czukar: So in both those cases in terms of case management and respite—respite is mentioned as an aspect of care giver support because we know that it can be an outcome of a variety of different kinds of services that can be provided in different ways. So, again, it's to allow for flexibility and case management. Also, that term is not used, because it means many different things to many people and different kinds of things can constitute effective case management for different people, some of whom want something very structured and some of whom don't.

The Acting Chair: Thank you. Mr Wilson.

Mr Jim Wilson: Thank you, Ms Wallace, for your presentation and giving us a family perspective. You ended your presentation by talking about the cost of MSAs and in fact, in essence, raised the question of priorities; that is, if there's not enough money in the system, should the government be spending what is estimated to be a large sum of money in establishing and operating MSAs. The Catholic Health Association of Ontario has indicated to this committee that its estimation to provide nursing services alone through an MSA, administrative costs in Metropolitan Toronto alone—I think their assumption is there are 15 or 20 MSAs in Metro—would cost an additional \$7 million.

With that in mind—I think you've been following the reform of long-term care over the last couple of years—what was your original vision of an MSA? What were your expectations prior to reading this bill?

Ms Wallace: Quite a number of years ago there was a concept developed for one-stop shopping—by the secretariat for the aging?

Mr Jim Wilson: Seniors affairs, I think it was.

Ms Wallace: It talked about the ability to find all services under one roof so the people weren't, as happens in a lot of services, having to go 40 different places or spend eight days on the phone trying to find something. It was supposed to simplify things and make things much better.

We have a multiservice agency in Etobicoke. We have two other community health centres, which would also probably function in the same way. What can happen in that is that it can become so diversified, in that it's providing services to a community, that the critical services get sort of left behind and the fringe fund services take over. For instance, I would never say that it wasn't important to have a toy library, but I don't think a toy library supersedes psychogeriatric services. So I think there needs to be some clarity on what people can and can't do and where they can and can't expand in providing appropriate services.

I am concerned about the cost. At FAME, we have been sitting on committees for mental health reform and we are aware that mental health reform will go ahead \$62 million short of what we thought we had to start with. So cost for those of us in mental health is a rather large factor. If the health budget is losing that much from

mental health, what else is going? Where is money going to be found to do things when we're being told there's no money to do anything?

Mr Jim Wilson: When we first started talking about one-stop shopping, and then the term "MSA" came along, did you think the MSAs would be sort of a phone number you could call and get information and referral and perhaps assessment, or what they've become now, which is also they have a monopoly on delivering services? To me, they're two distinct things and yet this legislation binds the two together and mandates the MSAs to perform all functions.

Ms Wallace: I think there are a couple of things that have to be looked at. If you have an information outlet that people can access by phone, that's fine, but you're making some assumptions that people will know the right questions to ask. My experience is that people don't, that they are looking for something, but they don't know how to phrase it because they're not professionals asking another professional for something.

So I think it is important, although expensive, to have staff who can go out into the community, do assessments in homes and that requires more than an information service.

Mr Jim Wilson: Should they also be delivering the service that's recommended then?

Ms Wallace: I'm not sure. There are pluses and minuses to that, and I think if they are delivering the service, that there have to be a lot of safeguards put in and a lot of very careful evaluation mechanisms devised and implemented so that there's clarity that the service that is being provided is a service that's wanted.

Mr Jim Wilson: Because I think with some of the seniors' groups and the retired persons' associations—CARP—that appeared earlier, there was mention about some fear being expressed about the fact that the same group that now does the intake assessment and delivery of services is also the same group that you have to register your complaints with. In the mental health field, we've taken great pains or tried over the years to make sure there were separate avenues for complaints so that they wouldn't also—

Ms Wallace: I can tell you, it hasn't been very effective.

Mr Jim Wilson: No, it hasn't, and that's why I wanted to ask you. I'm afraid that with respect to this, although there is an appeal mechanism here to an outside board, I think the fear is that perhaps vulnerable people may not actually want to complain to the same people whom they rely on their services from. Do you have any comment on that?

Ms Wallace: I think that's a very serious problem and it certainly has proved to be a problem in mental health, even though there appear to be other avenues. A group that FAME is affiliated with, Quality of Care Coalition, has just written two papers on that, one about community services and one about institutional services, and our feeling is that there has to be an independent evaluation mechanism that people can access when they need to. They need to be able to make their complaints in such a

way that they are not victimized by the complaint process. It needs to be looked at very carefully and developed very carefully so that both sides are protected because one of the things to remember is that people can make complaints in such a way that they look very different than they really are, and staff can be victimized as easily as vulnerable people can be victimized. So there needs to be protection built in both directions on that.

I think, as a whole, the Ministry of Health has got to develop some much better evaluation tools. We've looked. We found some that we think are applicable in a wider range, but we very, very definitely feel that the evaluation has to be provided independently and it has to include interviews with people who are recipients of service, with their families and with people who have left a service because they didn't like it, and then you get a broader picture of what's happening.

1630

The Acting Chair: Thank you. The parliamentary assistant has a question.

Mr Wessenger: Yes, I just have a question. I noted you raise some of the problems with respect to the individual not being able to get services and you mention about the appeal process not being maybe the most effective way in any system of really dealing with a complaint. If you have to go to the appeals process, it means the system probably has not worked very well prior to going to the appeal level.

In your experience in dealing with various organizations, which I assume you have dealt with community-based organizations—

Ms Wallace: Yes.

Mr Wessenger: —those that have local boards as distinct from those that have larger models, including government models, do you find the process of dealing with a complaint more responsive if you're dealing with a more community-based organization as distinct from one at a provincial level?

Ms Wallace: The question is not an easy one to answer because when you're dealing with the community agencies, you're dealing with probably one or two services in a community. So if you complain long, loud and hard, the answer is, "Fine. Don't use our service," and everyone whom you would want to refer there is then cut off, or if a family does that, then they are out on their ear.

Whereas, for instance, in our area of focus in mental health, if we have a complaint about a hospital, we can be pretty vocal about that hospital because it's going to be really hard pressed to turn people down. I mean, hospitals just aren't supposed to do that. We know they do, but they're not supposed to.

So the community agencies, I think, probably in the long run are harder to complain about, but they are easier to deal with on an informal basis because you can pick up the phone and say, you know: "Hi, Joe/Hi, Jane, there seems to be a problem here. Can we do something about it?" But if it can't be resolved that way, then you're pretty well dead in the water. Whereas, a clearly independent evaluation mechanism would remove that and, I

think, provide a much better structure.

The appeals process, I should say as well, for seniors can be a very, very cumbersome thing and very, very frightening. There are a lot of seniors we work with who would like to complain about the kind of care their relatives get and they are terrified. They just can't do it because they've been brought up not to complain about professionals. They've been brought up to believe that if the doctor or the nurse says something, it's clearly next to God and they have to be wrong and they must adjust themselves to what's being said or done.

So a formal process like that is necessary, but it's also not enough because it doesn't address the very reality that a lot of seniors live with, and particularly if you're looking at seniors whose first language isn't English.

ONTARIO NURSING HOME ASSOCIATION

The Acting Chair: The next presentation will be made on behalf of the Ontario Nursing Home Association. Welcome to the committee. Please make yourselves comfortable and before you begin your presentation, please give us your names.

Ms Pat Morden: Good afternoon. I'm Pat Morden and I'm the vice-president of government relations at the Ontario Nursing Home Association. I'm also the administrator of Shalom Village, an organization in Hamilton which provides long-term care, sheltered housing, day programs, kosher Meals on Wheels.

Ms Shelly Jamieson: My name is Shelly Jamieson. I'm the executive director of the Ontario Nursing Home Association.

We very much appreciate the opportunity to share with you the experience of our members in addressing the challenges of providing health and social services in the various communities where our members are.

As background, the Ontario Nursing Home Association represents some 296 private sector organizations. They're both profit and not-for-profit organizations and they provide long-term care services under licence from the Ministry of Health to almost 28,000 Ontario citizens and their families. We believe that our collective experience in providing services to adults and young adults requiring ongoing health and supportive services across this province can provide some useful insights to the work of this committee.

Throughout the consultation process on the needs for reform in long-term care, our association has been very active, as many of you know, in initiating and promoting changes that will ease access to information and services for seniors and others in need of similar care. As one of the major publicly identified access points to long-term care services—and that's what nursing homes are; they've been traditionally seen as that access point—we recognize the impact that more accurate and timely information about services can have on an individual's ability to remain in their community and to make well-informed choices.

While the ONHA supports the one-stop shopping concept, it's very concerned that the method of delivering services proposed today could create a very bureaucratic and expensive approach.

Our close contact with seniors accessing services, both in the community and within our facilities, and our active involvement in the evolution of change have reinforced our opinion that the intent of the impetus to develop one-stop access was just that, to provide a single entry point for information and for counselling on what services were available and how they could be accessed. At no time did we understand that the thrust of this bill was to support the government to be an exclusive, monopolistic gate-keeper and provider of service.

While consumers do need one point of entry, setting up one agency and eliminating the various network of service providers, including Red Cross, Saint Elizabeth, VON and private sector agencies, will result in a loss of staff available to meet specialized needs and the multitudes of volunteers who provide added service and support. It is highly questionable to us that one agency will be able to meet all of these needs.

It is our understanding that the plurality of service choices and options in Ontario was a strength of our health care system. In our opinion, the proposed structure of the MSA dramatically reduces consumer choice. Rather than the creation of a huge bureaucracy that, at best, only duplicates services already available to consumers, we support the development of a consumer-based information system used by all participants in long-term care: people who are accessing nursing homes, homes for the aged, chronic and acute care hospitals and various home care agencies. Such a system would enhance significantly individuals' access to the system and facilitate appropriate allocation and use of community resources.

The ONHA believes that a balance of public and private sector agencies delivering services best serves the needs of the consumers in this province. Private sector nursing homes, commercial home care agencies, retirement homes and laboratories, all these groups provide services that we feel are of equal or better quality than the public sector when quality is evaluated by comparison to provincially established standards.

The reduction of all non-MSA service providers, as proposed in Bill 173, will not, in our experience, improve quality of care, will not improve accessibility, will not improve service delivery and will not save money. Repeatedly, we have asked for information which supports the fact that in fact this approach would do that and we have yet to see or hear of any. Issues of accessibility, quality service and cost-efficiencies are the elements that matter in creating the reformed long-term care system, not the ownership of the agencies and facilities. It is management, not ownership, that is the key to the delivery of accountable, cost-effective care based on approved standards.

Evidence suggests that the private sector is efficient, offers equal quality, puts much-needed competition into the system, raises its own capital and contributes to society through taxes and employment. One of the many drawbacks of Bill 173's model of service provision that we feel needs emphasis is the creativity and innovation which comes from individuals motivated to demonstrate the "profitability" of their service; that is, wanting to

ensure the ongoing viability of their service by being the best they can be, being respected, being chosen as a service that people want and value and by ensuring value for the dollar.

1640

Bill 173 proposes to develop a service which enables the service provider to decide who needs their service, how much they need, how much it will cost, as well as providing the service. This proposed model has no inherent incentives to be efficient or to provide quality. By evaluating its own effectiveness it will, however, provide a mechanism for life in perpetuity with potentially no link to the real needs. Fee-for-service physicians in this province currently practise using this type of model. The incentives for inefficiency produced by this type of service arrangement are well known.

We wonder whether the decision to restrict private and public agencies was based on any economic argument or merely an ideological one. It's hard to imagine that in the 1990s, even a socialist ideology would completely exclude the private sector and completely destroy voluntary agencies.

The Minister of Finance's very marker for economic recovery is reportedly small businesses. The businesses that will be ruined by this bill are the very ones which the Minister of Finance is relying on to pay taxes. MSAs won't pay taxes. We thought entrepreneurship was the mode of business most likely to succeed in the 1990s.

Ms Morden: The MSA concept proposes to create operational efficiencies by being large. We believe the facts show a much different conclusion. This model will create a system which is far more costly to operate and, as Shelly said, we've been looking for the exact dollars but those aren't available, and therefore, what will happen, for equal dollars as today, we'll be providing less service to the community. As this government knows, larger workplaces are now more costly to administer because of the various labour law requirements.

Why would the current system work better? Non-profit providers create efficiencies using volunteers to augment their staff. Volunteers will be lost to the MSA, for reasons I will detail in a moment. Profit-making organizations create efficiencies based on sound business practices with the goal of keeping their businesses afloat, practices which must ensure a quality service or their goal of continued success will not be met. People just won't use their service.

The proposed MSA, or monopoly on services and access, will not benefit from either of these efficiencies. Concurrently, the cost of ending the existing services, terminating staff, starting a new service and hiring staff to do what others are already doing will be very costly, not just in dollars but in individuals.

Bill 173 will be equally devastating to both the volunteer non-profit agencies and commercial agencies, as they both now share the same risk of losing their businesses. Thousands of workers will lose their jobs when non-profit and commercial agencies they work for are eliminated by the creation of the MSA. These workers, with the skills and knowledge to do the job, will

also be disadvantaged in applying for MSA jobs because of the social contract obligation to place health workers displaced by hospitals.

I previously mentioned volunteers. As a provider which offers a multicultural service with a strong volunteer base—the base is not just dollars, it's also the time they give us—our experience, in relationship to the other long-term care providers and community agencies, is that the volunteer has a clear link to Shalom Village or to the service they volunteer to.

What would be the link to the MSA? I don't think any other large government agency is swamped with volunteers, I just don't see it, and I hesitate to think that the MSA would be any different; thus, the tangible and the many wonderful intangible benefits of volunteers in service provision are going to be lost.

Bill 173 proposes that the MSA will provide all but 20% of the services it needs. Once again, the needs of the cultural and ethnic groups in this province will be missed. Small service groups that provide language-specific, kosher Meals on Wheels, those will all be lost.

The MSA will bring one-stop shopping to health care, literally providing only one place to shop. What it will mean to a person needing in-home care is that if the MSA does not meet his or her needs, whether they're clinical, ethnic, spiritual or linguistic, there's nowhere else to go. The consumer will lose all choices. Under the current system, persons who are unhappy with the service can choose another. Vulnerable, ill people are unlikely to complain about the care they receive. That's difficult for all of us, but most especially with the MSA when your complaint will actually go to the person who decides whether you can have service. People are not going to complain.

Canadians are well known to be private, reserved people. I can't imagine that our seniors want to spend their last years having their lives managed by Big Brother. "I'm from the government, I'm here to help you" is one of the most distrusted phrases around. Many Ontario citizens have struggled their whole lives to have choices, to have some control over their lives, to decide what they need and who can help them.

Many seniors I meet have risked life, limb and family to achieve such rights. In one move, the development of the MSA will deny them these hard-sought ideals. When they asked for easy access to information, they were not asking for someone to take control; rather, a system to facilitate their own decision-making, information counselling, to help them make the right decisions, use the right services.

This monopoly of the MSA will make the decisions as to what is best. This type of thinking smacks of agism, which is racism directed towards the elderly. "They don't know what's good for them, so we'll decide." It's interesting that for the disabled the same government is giving the individuals the control, establishing what dollars are available and allowing the individual to choose how these dollars are to be spent. The disabled are being given the opportunity to choose what is most important for their care and options to meet their needs. What makes the government feel the elderly need a

paternalistic system which denies the ability to have choice?

The long-term care sector, which ONHA is very familiar with, has developed an effective model for managing a multitude of service providers. The ministry has established standards for care, guidelines for access, methods of evaluating care and dollars for the health portion of the service. Through a funding mechanism, agencies are encouraged to be efficient in the accommodation envelope, but not permitted to use care dollars for anything other than care. Dollars received in accommodation over and above expenses can then be used to enhance services and structures to ensure the ongoing viability of the particular organization. This is true of both profit and non-profit organizations. A similar arrangement with government establishing core services, dollars available and in consultation standards for care, could combine the concept of ease of access with the clear benefits of encouraging a variety of service providers, which will also maintain efficiencies and volunteers.

ONHA clearly recognizes the need for change in the system, especially the provision of timely and accurate information about long-term care services to the consumer. Bill 173, however, goes way beyond this concept without, we believe, enhancing care or quality of service.

The following recommendations would, we believe, address the identified gaps in our current system while maintaining the choices currently available to the consumer and maintaining the tax contributions that drive the government's ability to initiate change and enhance service:

- (1) The development of a consumer-based information system to ease information flow to all users of long-term care services. The piloting of this system in both rural and urban areas would provide useful information.

- (2) The government determines the core services to be provided and equitable, measurable standards of service be applied across the province using the current range of service providers.

- (3) Maintaining the current balance of service providers to ensure consumer choice and meeting of individual ethnic and spiritual needs.

Ontario's consumers asked for clear access to information so they could make an informed choice. Bill 173 does not meet this need. Bill 173 takes away choice and makes all the decisions about services for the individual. The bill proposes that the government will become the monopolistic provider of home health care services. Tax dollars, consumer choice, jobs, quality service and thousands of volunteers will be lost by the implementation of Bill 173.

We strongly encourage you to re-examine the goal of the Bill 173 process, which we believe was to develop a cost-effective system of consumer information to ensure access to appropriate long-term care services. Using the insights gained through this review process, restructure the bill to ensure it meets the need while preserving the quality choices now available to the citizens of Ontario.

We would be happy to answer any of your questions

or to provide further information if it would be helpful.

Mrs Sullivan: Thank you for a coherent criticism of the structure, the model that's been selected by government for long-term care reform.

I'm interested in the point that you make that the issues that are addressed in this particular bill relate more to the structure, the management surround, rather than the content, the quality and the services which are to be provided. I think, for the most part, that's true, other than the issue of the basket of services which is defined at the beginning of the bill, where there's a level of standard that is to be implemented across the province, and of course we have had a problem in the past with an equivalency of servicing in various areas of the province.

1650

We also share, by the way, your concerns about the fact that there haven't been the cost studies and the feasibility studies haven't been done with respect to this model. What kind of incentives do you think should be put into place to ensure that the quality and efficiency that ought to be associated with long-term care reform are in fact included as a part of that reform?

Ms Morden: I think the incentive for efficiency from our perspective is, number one, that there are measurable standards that are in some way evaluated not by the agency providing the service, and the efficiencies can be structured, we believe, within the funding. If the dollars are established and guidelines in terms of those standards are established and how the dollars are to be spent, then again efficiencies—you want to save money, but efficiencies, if you have a variety of agencies, some may use it for different things. Within my facility, I might use it to develop a new program that I can pay for. Another group might do something else with their efficiencies; you may even want to put guidelines on that.

But I think having standards that are measurable and that people are called accountable for those—and the core dollars are already established, so you know how much you're going to spend, but those two things could really put some limits on it.

Mr Jim Wilson: Thank you, Ms Jamieson and Ms Morden, for your presentation. I paid attention to every word in it and just want to commend you for an excellent presentation. Again, you've shown courage in often beating back the trend to come and support government legislation and bring us a perspective with some very good ideas.

I'm absolutely intrigued, and it's been mentioned in roundabout and in some direct ways by other groups, the need for an information system. When you think about it, if the government would adopt a proper, smart health card system, that is the basis of a good information system, for also your long-term care system, the drug benefit system and many other systems as governments may seek to add to the information on line. Unfortunately, the government is taking a very expensive, wrong decision to simply slap a photo on a magnetic strip card.

I think you're right because you point out quite correctly that one-stop shopping, one-stop access, was sold to the public for many, many years as a fairly simple

concept that we all understood, and you explain that in quite good terms. I don't think the public, to this day, understands what a monopoly is being set up.

I know, and we all know, that the people of Canada and the people of Ontario hate monopolies. They absolutely hate monopolies. Whether it's the phone company or the Beer Store or the liquor store or numerous other entities in our society, they're a constant source of complaint when people start to think about monopolies. In fact, government is charged with the legal responsibility in our society to prevent monopolies, and here we are setting one up in health care and trying to rid the system of what I think is healthy competition and other things.

I don't really have actually a specific question because I agree with what—

Mrs Sullivan: I do.

Mr Jim Wilson:—you're proposing here. Your final remarks, as I recall, are that the process here needs to lead towards a restructuring of the bill. I think to do what you want to accomplish, we would basically have to rewrite the bill outside of the bill of rights provision and outside of perhaps some of the purpose clauses. My caucus has a great deal of difficulty supporting this bill and at this point won't be supporting the bill on third reading unless we can get some specific amendments in.

I leave you with a semi-question here, and that is: Given that you know that the government has a monopoly on the votes in the House too, certainly a majority of the votes, a monopoly on the way legislation will go, this bill will pass; we can undo some of it when we form the government next year. However, what would you like to—

Mrs Sullivan: Fat chance.

The Acting Chair (Ms Yvonne O'Neill): For a person who hasn't got a question, you have taken quite a bit of time. Are you going to complete this then?

Mr Jim Wilson: I'm not done.

Interjection.

The Acting Chair: Okay. Mr O'Connor.

Mr Jim Wilson: One minute, one minute. I just want to leave it with—perhaps you could give us some specific amendments that you'd like to see in the actual Bill 173.

Ms Jamieson: We'd be happy to do that. I would just like to add, we had quite a spirited debate at our board about whether to come today or not. We have lots of things to do. We have some of our own fires and, frankly, this is a peripheral one, but we decided that this is something we've been saying for six months at meetings to Karen Goldenberg, to all kinds of people, that we were concerned, we wanted to see pilots, not pushing ahead, we wanted to see cost data and we keep getting, "Thank you very much," and away we go. So we decided that it's not fair to be critical of the process and then not to participate right at the end. On that basis, we made the decision to come today.

Mr Jim Wilson: Thank you.

The Acting Chair: Mr O'Connor.

Mr O'Connor: I appreciate you coming and sharing some of your thoughts with us.

I guess part of the concerns that I have in some of what you say is that what has evolved to bring the MSA forward won't allow the consumer the choice, the opportunity to be involved in the provision of care, the choices of provision of care that can and will evolve out of this.

We had a presentation late yesterday by Victoria County Community Care, and they shared with us what they saw as services that evolved and they came together. Of course, any type of community like that is going to require a great amount of volunteerism, it's necessary, and they've been able to maintain that and it has evolved.

What we're trying not to do here is to establish an agency, a brokerage. I know that the previous government had set that out as a model. In fact, our early consultation papers had said that we would move towards a brokerage model and be the purchaser of services and put that out to a very extensive consultation. It's from those consultations, though, that the idea of a brokerage model purchasing services wasn't recommended back to the government.

I just wondered if maybe you have some thoughts that you could add in how we could—because it is very important that the consumers—that's the focus here, the consumers, the people whom we want to provide and continue to provide care for in a better fashion than we have always in the past.

Ms Jamieson: We certainly support that.

Mr O'Connor: And a continuum of care. If you could maybe give us some suggestions how we can approach it from a consumer element.

Ms Jamieson: I think the interesting piece about the consultation is, it's like all new concepts which are somewhat radical. When one-stop access came out people were horrified because it proposed huge change to the system and people felt threatened. What I find interesting is somehow we charged ahead to this bigger model, and I'm not sure the consumers have ever asked for anything different than they were asking for in one-stop access. I think the kind of model that was proposed with one-stop access would be very saleable to consumers and to service providers today, and you might get those kinds of efficiencies you're talking about.

I know Victoria County Community Care services. They're an excellent organization. I can imagine them making business decisions about how they should provide services in their community by amalgamating services. That's something that comes together naturally.

Where I think consumers lose choice in here is not in choice in terms of access to services, it's choice about who delivers the service. I think when someone who's telling you about the range of services also is in any way related to the person who's delivering services, we have an inherent problem in the system relative to accountability and speaking up. I think that's where our concerns have led.

Unfortunately, whenever you bring up the fact that you think that this model isn't good, we get slapped—a lot of service providers but certainly the ONHA—with the thing that we're not concerned about what the consumers think. I talk to consumers all the time in my personal life and

my professional life. They think they need to go somewhere and make the job easier to get into the system. I agree with them, and we would support anything that we thought did that, but we just don't think this is it.

Mrs Sullivan: I appreciate this opportunity, because yesterday we had a comment from Mr Quirt with respect to the manual which is being developed for the community service agencies. He indicated that there was such a happy and wonderful acceptance of the manual in the long-term care facilities that of course that approach would be taken. So I said, "Well, that hadn't been the experience that I had heard about," and I thought now is a particularly opportune time for you to comment on the specificity of the manuals.

Ms Morden: I can comment on that, because I deal with that manual every day. I think that there is an acceptance of standards. There has been some discussion around particular standards, how they're to be implemented and how people put priority on them. That's always going to go on when you're trying to make professional, ethical decisions about care, but I think that if you talk to any long-term care operator that's looking—because we've been asking for standards, that there's an even choice for people, that people can have a guarantee when they want to make a choice of a long-term care facility, that they can really be guaranteed that there are certain standards of care that are going to be carried out in that home. Although there are definitely problems with process—you've got government setting standards and people who are independent wanting to make those decisions, some difficulties in priorities—I think that there is acceptance of the idea of standards and having standards.

Ms Jamieson: I think perhaps the birthing of that manual has been difficult and perhaps there are more restrictions within the manual than we think are necessary to measure whether you're doing a good job. So, it can be prescriptive in areas where we should be looking at the outcome, not how we got there. At the end of the day, I agree with Pat, the manual is providing an equal playing field and it's going to make us all, homes for the aged and nursing homes, equally accountable, and we don't shy away from that.

The Acting Chair: Thank you both for coming. I'm glad you made that decision.

The committee recessed from 1703 to 1711.

ONTARIO COLLEGE OF FAMILY PHYSICIANS

The Acting Chair: We resume the social development committee and we now are going to deal with the presentation from the Ontario College of Family Physicians. I understand that we're going to have an audiovisual presentation. Perhaps you'd like to introduce yourselves as we begin.

Dr Rick Mann: My name is Dr Rick Mann and I'm the president of the Ontario College of Family Physicians. We brought the audiovisual equipment along with us to try to warm up the room for you. Hopefully, the light will allow us to do that. Sitting beside me is Dr David Keast, a family physician from London, and assisting us in the audiovisual department is Ms Cheryl

Katz who is the executive director of the Ontario College of Family Physicians.

We want to thank the standing committee on social development for this opportunity to make a submission in respect to Bill 173. Dr Keast and I are appearing on behalf of the Ontario College of Family Physicians, a voluntary, not-for-profit organization of approximately 5,000 family physician members serving in cities, towns and villages across the province. We are the provincial chapter of a national organization whose mandate is to promote high standards of medical care and education in family practice.

As family physicians, we strongly believe in the principles of continuity of care, cost-effective care, community-centred primary care and quality management in meeting the many diverse aspects of health, medical and psychosocial needs.

The Ontario College of Family Physicians is concentrating its submission on those aspects of the legislation which may impact on the principles of quality, family-centred primary care.

The stated objectives of Bill 173 are as follows: to ensure availability of and equitable access to community services rather than institutionalized care; to improve quality of community services and health promotion of service consumers; to simplify and improve access to community services; to promote efficient management of human, financial and other resources involved in the delivery of community services; and to encourage community involvement.

The Ontario College of Family Physicians supports the vision of an integrated single source of community-based service. Realizing this vision presumes appropriate assessment of the nature and frequency of services required.

Dr David Keast: I want to speak to you for a few minutes about input into decision-making. Dr Mann and I are going to pass the ball back and forth here. I'm going to leave what's written here for you to read at your own leisure on the couple of ones that I'm going to address and just simply make some comments about it, sometimes from my own personal experience in providing care to patients in the community.

The first one is on input into decision-making. Really, in the legislation, in my reading of it, anyway, there doesn't appear to be anywhere any involvement for physicians in providing input into the decisions that are made for the eligibility and the appropriateness of the services for the patients. We think that may be a bit of a mistake.

We have a long-term longitudinal knowledge of the patient in their family situation. We often care for their spouses, for their children, for their parents, for other members of the family. We live in the communities, and we often have an exceptional knowledge-base of these particular patients that would be helpful in determining the services that these people would require.

We think that it's really important that the legislation have somewhere in it some way for health professionals such as physicians to have some input into determining

the nature and the need for the services. We think if that isn't there, there could be mistakes made, diagnoses missed, services duplicated that may not necessarily be appropriate.

Secondly, I want to talk to you about access to service. This somewhat upset me when I read the bill because I had just gone through an experience with an 85-year-old woman in my practice. She is widowed. She has no family in town and basically, I'm about the sole contact that she has in the city other than her church and some neighbours. She has diabetic polyneuropathy. She is weak. She falls. She fell in her kitchen and she fractured her wrist. She was taken by a neighbour to the emergency department and a cast was placed on her wrist and she was taken back home. At 5:30 on a Friday afternoon she called my office in a panic. She had no support to turn to. She didn't know what she was going to do for the weekend because she didn't know how she was going to feed herself, wash herself, get all the activities of daily living done, and she was frightened and alone. She desperately needed some homemaking service and reassurance and somebody even just to check on her.

According to the bill, I would have to say to this woman, "Well, certainly these services are available, but you call and ask for it, please." We really think that there should be some way in which family physicians can advocate for their patients to obtain services when patients may not be prepared to advocate for themselves.

Often elderly patients don't want to make a fuss. They don't want to disturb people. Consequently, they won't be aggressive in pursuing their needs, and sometimes that's a role that I, as a family physician, take on for my patients. It disturbed me somewhat to see that there was nothing in the bill that permitted other people to access the services on behalf of needy persons.

Dr Mann: I'd like to talk for a moment on community supports upon discharge. The multiservice agency concept may be a cost-effective alternative to institutionalized care in larger population centres. However, in rural and remote centres, it may not be cost-effective to provide specialized professional and support services in the home; for example, occupational therapy, physiotherapy, speech language pathology etc.

In the community where I live—I live in Bruce county—there is a vast area to be served in that county. Although it may be very cost-effective where there is a population and patient density, it may not be very cost-effective for service providers to be travelling over 120 miles in one direction on a daily basis to look after individuals. If I think or we think that Bruce county is somewhat remote and isolated, imagine how more difficult that may be providing some of those services in a cost-effective manner in the northeast and northwestern part of the province.

The appropriate level of community services must be readily available in all locations across the province before the patient is discharged into the community. We cannot allow people to fall between the cracks. If these services are not available in the community, then we fear that the burden of care falls on the family care givers, who may be ill-equipped to meet the increased demands.

In the absence of appropriate and timely community support services, deinstitutionalized care may not be preferable for patients or their family care givers. So the infrastructure must be in place before we look at deinstitutionalizing people. We don't want to see the type of thing that happened when the psychiatric hospitals were closed happen again, where people were basically dumped on the street with no support services. That has to be in place in part of this legislation.

Deinstitutionalization must be coordinated with the patient's family physician, who knows the patient, to achieve seamless care. Failure to coordinate community care with the family physician may result in increased reliance on walk-in clinics and hospital emergency departments, at greater cost to the health care system.

1720

Dr Keast: I want to speak to you for a moment about the bill of rights part. We would strongly support a bill of rights for recipients of services, but on the other hand, we wonder where there is a bill of rights, if you would, for the service providers.

Part of my practice also involves working in a long-term care institution and we have a number of elderly, demented patients in that institution who are at times both physically and verbally aggressive and sexually inappropriate. With the extension of increased services in the home and no protection for service providers in the bill, we are somewhat concerned as to what may happen to nurses, occupational therapists, physiotherapists and homemakers at the hands of some of the recipients of the services.

These people often don't mean to behave in this way but they do. If people felt that they were forced to provide the service, regardless of what was going on, we feel that would be a severe mistake. We would support some kind of rights for the service providers as well.

Next, I'd like to talk about equitable access to seamless care. Basically, what seems to be happening at the moment is that we're moving to a regional concept of budgeting and governance in the health care system, the district health councils, if you wish. At the same time, this legislation sets up the MSAs, which are designed in specific geographic areas. For example, it is rumoured that the Toronto region may end up with 15 or more MSAs, and in other areas you may have one MSA for a region.

The worry that we have is that not all services may be available in all MSAs and we'd hate to see that the services become regionalized in one MSA. Let's say, for example, that linguistic services were available in greater Metropolitan Toronto, because you have a large number of ethnic communities here. In a smaller community just to the north of Toronto, there aren't that many people requiring a specific linguistic service, but there might be one recipient in that area. We think it would be a mistake if that person couldn't get that service, just because they were in the wrong geographic area.

We would hope that there would be some interplay between the MSAs so that a neighbouring MSA that did have that service could provide it to an outlying area where there were fewer recipients who needed that. So

what we're looking for, I think, in this idea of equitable access is that there's some flexibility in providing these services.

Dr Mann: We have, therefore, three major recommendations that we would like to make to this committee: number one, that the integral role of the family physician be recognized and that provision be made in the bill for medical input into decisions regarding eligibility for and the nature of services; that access to the services by a physician on behalf of their patient be incorporated into the bill; that there be formal communication links between the MSAs and the patient's family physician so that duplication and fragmentation can be avoided.

Secondly, we would like to suggest and recommend that discharge planners in acute and long-term care institutions should also be able to have access to services as part of the discharge planning process.

The third recommendation that we would make is that there should be protection in the legislation for not only the service recipient, but also for the service providers.

In summary, then, the Ontario College of Family Physicians supports the concept of integrated and coordinated access to needs-based and culturally sensitive community care. Bill 173 appears to have developed a process to simplify access to care. However, better access to service is not the same as better service. Long-term care reform must ensure that high-quality, cost-effective services are available universally throughout the province.

Ms Carter: It's good to have your input to this. Obviously, physicians are a very important part of the whole picture. I just have one or two comments, and then something I'd perhaps like the ministry to comment on. I guess one of the objectives of this legislation is to make sure that facilities and all the different kinds of care provision are uniformly spread across the province. I think we know that some districts are very, very well catered to already and others are not, so I kind of feel that your fears that some areas will not be well catered for are really the present situation and what we're trying to do is to fix that.

Of course, we don't have a cookie-cutter model of an agency; this is something that is going to develop in each of the local areas so that where you have a rural area, obviously it will develop in a different way than it would in Toronto, so I hope that's a problem that won't arise. We have mentioned just earlier the Victoria County Community Care, which of course does function in a rural area and already has a lot of similarities to what we see developing under this legislation, and it seems to be doing an excellent job.

Now, you are concerned about the involvement of physicians; you see people getting into touch with the agency and having their needs assessed and you wonder where the physician involvement comes in, but I guess the answer is that there are a lot of things that aren't spelled out in detail in the act because if we spelled everything out, it would be an enormous volume instead of just a comparatively small number of pages. I would have thought that it's self-evident that the physician's opinion has to be a large part of assessing a person and that obviously you will be involved.

Now whether a doctor could access the system on a patient's behalf, as in the situation that you mentioned, the lady with her arm in a cast, I would not have thought that was a problem, but I would perhaps ask for an opinion on how we would be fixed in that kind of situation.

Mr Wessenger: I will ask Mr Quirt to reply to that. I think it's fair to say yes, there's no reason why a physician cannot continue to access the MSA. I think there are also some provisions under regulations perhaps for some procedures to be laid down that may involve more formal involvement of the physician.

Mr Quirt: We really don't foresee a great difference in how clients would access the long-term care system with the advent of the multiservice agency. Clearly, now physicians are a major source of referral to our community-based long-term care system. We expect they'll continue to be that.

There will be some differences in terms of their formal role as gatekeeper and I think, as other physicians before the committee have suggested, that services like placement coordination and the proper assessment on a multidisciplinary basis of the client and family need is an assist to the physician. We certainly don't foresee any change in how referrals would be made from physicians.

1730

As you pointed out, if the bill leaves the impression that you would have to say, "Sorry, I can't phone on your behalf; you're going to have to make your own phone call," then we've created the wrong impression with the bill. You'd certainly be in the same position to make your referral as you are now, and obviously, as is the case now in the system, the client and family are going to have to be in agreement that the long-term care services in the community are appropriate and they're going to have to agree to receive those services, but that certainly is the case now with home care.

It's conceivable that multiservice agencies would be able to provide services like a nursing visitor, a physiotherapy program, without necessarily the doctor prescribing it, as might be the case now with home care, but clearly the physician is one of the important players in a multidisciplinary approach to service, and we'd hope you'd have a better team of colleagues to work with with the advent of the multiservice agency.

Mr Jim Wilson: Thank you, Dr Keast and Dr Mann, for your presentation. I don't think there's any given in the legislation that physicians will necessarily be involved in assessment. I do welcome comment from the government, but it seems to me that these MSAs will have to be hiring people to do assessments. Whether that's going to be registered nurses or other people who have appeared before this committee and told us that they're equally capable of doing the job is something that we simply just don't know at this point, but it would seem to me you'd have to have full-time people available at the MSA to do assessments.

I do want to ask you, though, when you talked about deinstitutionalization, and it was raised earlier today, there's an ongoing concern that people continue to be

either discharged or deinstitutionalized in our society without the services in the community and that really nobody seems to have any responsibility for those decisions. As you said, the 85-year-old woman called your office as a last resort, not knowing where else to turn.

Have you given any thought that perhaps the MSAs in this case, as part of this new model, should actually have responsibility for deinstitutionalization, have some sort of legal responsibility for the person's care who is discharged, because right now they could fall between the cracks and there's a complete runaround when you try to figure out what happened and who's to blame.

Dr Mann: Do you want to handle that one?

Dr Keast: Sure. Just to comment about the other comments that were made, the bill, to me, still doesn't specifically spell out that there is physician input into helping in the assessment. And don't get us wrong, we don't want to do the assessments. Family physicians strongly support an interdisciplinary approach to providing health care and primary care to patients, and part of that interdisciplinary approach becomes very important on discharge planning.

The comment that I would make is that, in my experience, the places where the difficulties arise are the nodal points; they're the transition points. I mean, people do okay when they're in an acute care institution, but things go awry when they get transferred from acute care to a chronic care institution, or they go awry when they get transferred from chronic care to home or from acute care to home. What we're really concerned about and what we would hope that the MSAs would address appropriately, is that there would be an interdisciplinary involving of all the appropriate disciplines, including physicians but not restricted to them, to be sure that transitions occur between these various places in a coordinated fashion with appropriate services in place.

The example that I mentioned of my particular patient, hopefully that would not happen now in London because we now have a quick response program and the people in the emergency department would have been able to access the quick response. But at the time this happened, it wasn't there. I was able to get something for her for the weekend and something in place.

What I was trying to say is, we don't want to lose that ability to advocate when it's necessary, but on the other hand, we don't want to be the sole gatekeepers. We just want to be helpful and involved and part of an interdisciplinary process that's involved in making sure that people get their needs met where they want them met, be it in a nursing home if that's where they would rather be, or in the community if that's where they would rather be, and it should be their decision as to where is the appropriate place to receive the service.

Dr Mann: To answer your question a little bit, Mr Wilson, I think that there will probably need to be some accountability, and I would sort of see that if the MSA is going to take the initiative into coordinating the services, that if people are falling through the cracks, they should have some responsibility as to that process.

Mr Jim Wilson: I think the bill of rights attempts to capture some of that, except it's not clear to me what steps the consumer can take to ensure that they don't fall between the cracks and that a body is ultimately responsible. The bill of rights, I suppose—we've been told you can take court action I suppose against the MSA if something goes awry, but you mention the deinstitutionalization of mentally handicapped individuals that all three parties are guilty of having messed up in this province, and it struck my caucus some time ago that perhaps some body has to have responsibility for all the transferring around that occurs, and that there be a legal recourse, a simple legal recourse for people.

Interjection: I agree.

Mrs Sullivan: You've raised a number of issues we have been quite concerned about and have stressed with some other intervenors before the committee, not the least of which is the inclusion of clinical factors in the assessment of the person who's seeking long-term care. We have learned in front of the committee that about 90% of individuals who are attempting to enter the long-term care system present with some kind of an acute problem, and that whether the services that are required are nursing or medical services, they certainly have to be considered a part of the care package, if you like, or care plan for the person involved and that the assessment doesn't simply end, that there has to be a mechanism through which there is constant revision and updating.

Dr Michael Gordon who appeared—actually he didn't appear for Baycrest. I was trying to remember what organization he appeared for, but anyhow, he appeared before the committee, and one of the things that he suggested that Baycrest had discussed was some kind of a medical adviser system within the MSA, particularly to assist in complex cases or in situations where the client doesn't have a personal family physician, and we know that situation exists. That's one of the things that we've been kind of interested in.

Our view is that we ought to be making an amendment to the section that says that the agency shall assess the person's requirements to expand the nature of the assessment in terms of the services that should be judged.

The other question of course that we've had is who would do the assessment and who would coordinate related and other professionals associated with that assessment, and we've had very strong interventions from case managers who believe that case management should itself be seen as a professional responsibility that has to be provided by the MSA.

I think that your point about multiple entry points into the long-term care system is an important one. The physician is certainly one place where I think the majority of people in Ontario have a comfort level and a trust with respect to the next step that would be taken. The hospital discharge program may also well have to be integrated in some kind of a more formal way.

There are other people in our communities whom we may want to—I don't know if you can legislate it, but you may want to acknowledge that a referral, for instance, from a clergy situation may be just as valid as a referral from a professional care giver.

One of the things that we're concerned about is that with the hospital restructuring that's being undertaken everywhere in Ontario, the pressure to reduce hospital stays and to move the patient to an outpatient or ambulatory care basis is in fact adding to the stress on our community services. Certainly in my community and in many other communities, facilities and services are not available in the community to replace the consistency of care that's provided in the hospital scenario and we see that as a problem.

I think your brief is a good one and we'll work up some amendments.

Mr Malkowski: Thank you for your points that you've raised. One thing I'd like to talk about is the community support available when the person leaves hospital. In large communities, such as Toronto, there are quite a few support services available, but, say, in smaller or rural areas, such as Manitoulin Island, there may not be as many support services available. So what would you feel would be a cost-effective way of providing these support services such as the MSA or what would be another cost-effective option for providing support services once people are discharged?

Dr Mann: That's a really difficult question. One of my concerns with the bill is that we may be raising expectations for the public that we are not going to be able to provide the services for, from a financial point of view.

Those are things that we have to look at, certainly, and it may be more appropriate, instead of having individuals at great distances from one another, perhaps having types of care institutions that would be able to provide the care for those people, and, if they're ambulatory, then perhaps coming into a centre to have the services—physiotherapy or occupational therapy or nursing services, for example—within a community, not coming down from Manitoulin Island to Toronto, but somewhere having an area, Gore Bay or an area, Little Current, for example, where the services could be provided for people who could come into the institution there.

That may be a more cost-effective way of providing services for those whom we can do it that way for. There may be people whom we're going to have to go out to the community, into their homes or where they live, in order to provide the services and I think we'll have to recognize that there are some things that are going to cost and if we truly believe that we must and should provide these services for these people, then we're going to have to look at finding ways of financing it.

The Acting Chair: Thank you, Dr Mann and Dr Keast. I would like to now mention to the viewers that the social development committee hearings on the long-term care Bill 173 will no longer be televised as we go on the road to Hamilton, to Thunder Bay, to Sault Ste Marie and to London. We hope to be back with the viewers towards the latter part of these hearings, but for the next few days and weeks we will no longer be televised on the subject. I now adjourn the social development committee to Hamilton, tomorrow morning at 9:30.

The committee adjourned at 1745.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Chair / Président: Beer, Charles (York-Mackenzie L)

Vice-Chair / Vice-Président: Eddy, Ron (Brant-Haldimand L)

***Acting Chairs / Présidents suppléants:**

McGuinty, Dalton (Ottawa South/-Sud L)

O'Neill, Yvonne (Ottawa-Rideau L)

*Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

*Martin, Tony (Sault Ste Marie ND)

*O'Connor, Larry (Durham-York ND)

Owens, Stephen (Scarborough Centre ND)

*Rizzo, Tony (Oakwood ND)

*Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Also taking part / Autres participants et participantes:

Ministry of Health:

Czukur, Gail, legal counsel, long-term care legislation

Quirt, Geoff, acting executive director, long-term care division

Wessinger, Paul, parliamentary assistant to the minister

Substitutions present / Membres remplaçants présents:

Offer, Steven (Mississauga North/-Nord L) for Mr Eddy

Malkowski, Gary (York East/-Est ND) for Mr Hope

Sterling, Norman W. (Carleton PC) for Mrs Cunningham

Sullivan, Barbara (Halton Centre L) for Mr Beer

Wessinger, Paul (Simcoe Centre ND) for Mr Owens

Clerk / Greffier: Arnott, Doug

Staff / Personnel:

Boucher, Joanne, research officer, Legislative Research Service

Gardner, Dr Bob, assistant director, Legislative Research Service

CONTENTS

Wednesday 17 August 1994

Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,	
projet de loi 173, <i>M^{me} Grier</i>	S-1733
Ontario Community Support Association	S-1733
David Wartman, president	
Dan Stapleton, executive director	
Mark Adler, vice-president	
St Christopher House	S-1738
Lucia Furgiuele, director, Older Adult Centre	
Dorothy Myles, president, Older Adult Centre	
Ontario Physiotherapy Association	S-1742
Jennifer Cummings, president	
Cathy Hecimovich, board member	
Ontario Home Respiratory Services Association	S-1746
Blair Richardson, executive director	
Canadian Red Cross Society, Ontario division	S-1750
Bob Morton, president	
Nancy Bell, chairperson, homemaker services	
AIDS Action Now	S-1755
Darien Taylor, member, steering committee	
Brent Southin, member, provincial committee	
Canadian Association of Retired Persons	S-1759
Mrs Lillian Morgenthau, president	
Federation of Ontario Facility Liaison Groups	S-1763
Janet Allingham, president	
Margaret Gorman, facility representative	
Family Association for Mental Health in Etobicoke	S-1766
Judy Wallace, coordinator	
Ontario Nursing Home Association	S-1770
Pat Morden, vice-president, government relations	
Shelly Jamieson, executive director	
Ontario College of Family Physicians	S-1774
Dr Rick Mann, president	
Dr David Keast, member	



S-61

S-61

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Thursday 18 August 1994

Journal des débats (Hansard)

Jeudi 18 août 1994

Standing committee on social development

Long-Term Care Act, 1994

Comité permanent des affaires sociales

Loi de 1994 sur les soins
de longue durée

Chair: Charles Beer
Clerk: Doug Arnott



Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Thursday 18 August 1994

Jeudi 18 août 1994

The committee met at 0930 in the Ramada Inn, Hamilton.

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

The Acting Chair (Mrs Elinor Caplan): Good morning, everybody. Welcome to the standing committee on social development. We have a very full agenda today and with the agreement of all of the members of the committee, we'll be firm on our time.

There's 20 minutes for each presentation. The presenters will have the option of whether they wish to use their whole 20 minutes for presentation to the committee or whether they would prefer to make a presentation and allow time for questions and answers. Leeway will be given, of course, to the deputants in answering the questions and if we reach the 20 minutes and not all caucuses have the opportunity to question every presenter, they will have the opportunity to either speak to them privately, make other submissions—but I will ensure that the time is divided fairly among all caucuses.

Just for the information of everyone who's here in the audience, the members of the committee each have a nameplate, I believe, in front of them. The government caucus is on this side of the room, the opposition caucuses are on the other side. The committee members are Mr O'Connor, good morning, Mr Martin, Ms Carter, Mr Malkowski. The members on the opposition caucuses are Mr Jackson, Mr Wilson, Mr Kwinter, Ms O'Neill. The parliamentary assistant, who is with us today, is Mr Wessinger. Welcome everyone.

ONTARIO COMMUNITY SUPPORT ASSOCIATION,
AREAS 4 AND 15

The Acting Chair: The first presentation is by the Ontario Community Support Association, areas 4 and 15. Is Helen Schultz here, and Jessica Brennan? Please come forward.

Please begin your presentation. You have 20 minutes and we'd appreciate it if you'd leave some time for members to ask you questions, but it's your time and you can use it as you wish. I'll let you know when there's five minutes left for your presentation time.

Ms Helen Schultz: Good morning, everyone. My name is Helen Schultz. I am an Ontario Community Support Association director for area 15, which is Haldimand-Norfolk and Niagara. With me is Jessica Brennan, area 4 director, representing Hamilton-

Wentworth and Brantford. We are both employed by community-based community services agencies. Jessica is the manager of international and community services for the Red Cross in Hamilton and I am a community developer with Haldimand-Norfolk Community Senior Support Services in Townsend.

What we would like to do this morning is give a brief overview of what Ontario Community Support is and then list some of our areas of consensus with the legislation and then a few of our concerns. We expect that will take about 10 minutes, leaving 10 minutes for questions.

Ontario Community Support Association is a fairly new provincial association. We were founded in 1992 and we arose out of three former provincial agencies which offered Meals on Wheels, visiting homemaker services and home support services.

We have a volunteer board of 25 representatives and we have divided the province into 15 areas; two of the areas are represented here today. We also have community directors with broad experience in health and social services at the grass-roots level.

The services that Ontario Community Support Association advocates for are the full range of community-based services such as Meals on Wheels; homemaking; home maintenance; friendly visiting; Alzheimer day programs; congregate dining, which is known elsewhere as Diners' Club or Wheels to Meals often; foot care; client intervention and assistance, which we are funded for mainly in Metro Toronto; home help; care giver relief; emergency response; volunteer transportation; senior day programs; information and referral; intergenerational programs; and telephone reassurance.

Those are the core programs. I must emphasize that there are other funded programs which respond to local need, such as in my area in Haldimand-Norfolk. We do not have mental health counselling services, so we have employed a seniors counsellor attached to our home support agency to meet that need. There are also services in Hamilton responding to the need for grocery shopping. So we really feel strongly that as well as meeting the medical needs of seniors and describing the core programs, these other programs are essential as far as responding to local area needs.

Even though we come from the wonderful Golden Horseshoe, there's quite a vast difference in our areas. Hamilton is a large, urban, highly concentrated, densely serviced area, but the rural areas around Hamilton-Wentworth have very few services at this point. Similarly, Brant county has very few service providers for

community-based services. The Niagara area has a multitude of single-service agencies, mainly Meals on Wheels suppliers, some of which are not funded by the ministry, yet still offer a valuable service and are of course interested in what happens under redirection. Haldimand-Norfolk is the largest region in the province with the smallest population, so that presents geographic challenges. There are very few service providers in Haldimand-Norfolk because back in 1989 all the home support services were amalgamated under one umbrella agency which now has an administrative office and seven satellites. That's a fairly sophisticated home support system for that area.

I just want to outline briefly some of the areas of endorsement and I'll pass that over to Jessica.

Ms Jessica Brennan: You would have received yesterday a presentation by our provincial association and very much what you're seeing in front of you in the written documentation is what they would have given you yesterday. I understand there are some people here on your committee who were not there yesterday so, of course, please keep the copy. For those of you who have already seen something like this yesterday, between Helen and myself, we've made some minor adjustments based on area 4's and area 15's concerns, but really not very substantial.

What we wanted to do today—because certainly as you go around the province you're going to be hitting the other 13 areas for OCSA and we know you're going to be hearing very much what you heard yesterday, with some different emphases in those different areas as well.

What OCSA did was to certainly read Bill 173 thoroughly, get a sense of it from the provincial level, and then throw to the different areas a number of different issues that we as a group might endorse or have areas of concern. We then brought our concerns back to the provincial association. They then massaged that again in terms of presenting four or five main areas of endorsement and six or seven areas of concern. You will see in the document, at the end of the package that we've given you, 26 issues in all. So you will see that as you go through the province and you meet our other representatives in other areas there may be other issues that come forward to you as particular areas of concern. I just want to be sure that those of you who might not have yet had enough coffee for the morning are not just seeing something that you saw yesterday as well.

In terms of endorsement, then, certainly the association endorses the principles and the values of Bill 173 and feels very strongly about the bill of rights as an insertion into the bill itself, the rules governing approved agencies and proposed changes to the Public Vehicles Act that will facilitate different pieces of the system that's being suggested.

0940

In terms of the bill of rights, we are committed to a service delivery mechanism that's driven by the individual consumer needs, very focused on the consumer, certainly as a community services association with a large number of members who have traditionally been working 50, 60, 70 years in local communities. We have started

from individual consumer needs as our basis in the first place and, of course, we want to recognize and endorse the clients bill of rights as outlined in the legislation.

Certainly, in terms of governing approved agencies and the rules governing that, we agree that the functions of the approved agency should include and will include the following, and that's stated in the legislation, but to show our endorsement: to provide information referral regarding long-term care and support services; to offer a range of long-term care and support services itself; to integrate the functions of assessment and service delivery; to determine the eligibility for services; and to develop a plan of service for eligible persons with a review and revision of the plan when necessary.

Certainly, evaluating and revising and assessing—are we doing the right thing for the right people in the right way?—would be an important piece that the association will endorse.

Certainly, without large elaboration, the Public Vehicles Act allows the service provider to operate for the purposes of transporting persons, and including that in the bill, of course, is very sensible and we endorse that and thank you very much for considering that.

In terms of areas of concern, Helen will just outline some of those key areas, and then in terms of areas 4 and 15, we'll specify some of our particular concerns.

Ms Schultz: We have six areas of concern with the legislation and they include the following: the first is the areas that are not covered in the legislation; the second is the general regulations; the third is volunteerism; the fourth is MSAs; the fifth is categories of services; and the sixth is definitions. I'm going to touch on the general regulations first, then MSAs and then turn it over to Jessica.

On pages 35 to 41 of the bill are listed the types of regulations that have yet to be developed, and the list boggles my mind. It's everywhere from the duties of directors to listing the mandatory services, to eligibility criteria, waiting list, quality management, recordkeeping and so on.

These are vitally essential parts that are perhaps not appropriate to general legislation but are very critical to the way the service will be delivered and to maintaining the principles and values and retaining the philosophy of the community-based services as they exist now.

Each of those services arose out of a need and has a particular spot in the heart of their community. When I read this list of regulations that have yet to be developed, it seems like quite a heavy burden of rules and criteria that are going to be applied to all service delivering agencies no matter where they are in the province.

Quite frankly, we're not used to operating this way and when we see this list of regulations, not knowing what they will end up as—first of all our request is that OCSA be allowed to take part in developing those recommendations because we're really concerned that the flexibility and the local planning take precedence over a cookie-cutter approach or having regulations very heavily applied across the province. That part of the act is fascinating to me, yet hard to respond to because it's not

there yet and we'd like to be part of that if possible.

The second section I want to reply to is the multi-service agencies. OCSA has been a strong supporter of the development of multiservice agencies over the last few years with the caveat that they be developed through the district health council process following a community development approach and that any MSAs developed be neighbourhood-based and accountable to local needs. We believe in the principles and values stated in the partnership documents and reflected in the legislation and we thank you for carrying those through.

There's been a lot said, reminiscing about one-stop shopping, that sort of thing. To us, MSAs don't have to be an amalgamation of existing agencies. It could be functional integration, whatever works locally according to the desires of the local region. It's all fine as long as it's fine with the people who are planning it locally.

We also strongly agree that a board of health or a regional municipality should be considered after other community-based agencies. I think back to my own region of Haldimand-Norfolk, where we've just lost our medical officer of health, in part because of the difficulties he faces having to represent the Ministry of Health in that area, yet being, in essence, a regional employee. He's always caught in the middle. The director of home care reports to him. It's almost an impossible situation for anyone. So I see first hand every day the difficulty that would arise were a region to administer an MSA.

We do have one concern: There's one clause that the minister could designate the geographic area of an MSA. This raises little red flags for me because, again, I hark back to local planning. If local planning has assessed the natural community, then it seems rather arbitrary for the minister to then impose and say, "There will be this many MSAs," or, "This is the geographic area." That should arise out of local planning. Again, it's very important that that happen, because then the MSAs will stay responsive to local needs. That's what we're here for.

Ms Brennan: Just to emphasize Helen's point related to Hamilton-Wentworth, certainly we have in our area those people in Flamborough who may in fact have easier access to services in Burlington, but because of the way we divide things up, if there was an MSA only for Hamilton-Wentworth, then somehow Flamborough people have to come all the way out from their underserved area into the service area of the core. That also reflects some of the issues around geography and government distinctions for territories, when in fact natural territories already exist and we've been perhaps breaking the rules for some time anyway in that regard.

Ms Schultz: Just one final point that I have to make: No matter what form a multiservice agency would take, it is essential that a free flow of communication take place along the continuum of service delivery. We make an appeal to you for the dollars to fund a computerized information system, with all that it entails: training, hardware, software, the whole thing. It has to be standardized and it has to work well.

Ms Brennan: The only other comment to make is that certainly you have the document in front of you. Issues around definitions, issues around categories of services,

particularly looking at the way we call personal support services and such; It's in the document for you to read and I'd ask you to do that.

Certainly, the issue about protection of non-unionized workers, just in and of itself, is an issue for the association. But from this particular area, it's more the issue of keeping the linkages from the client to the person who's been serving them and that, as we develop the system, we don't dismantle the relationships that already exist between clients and people who have been serving them for years. That's one issue.

The final point, and the one I wanted to spend a few seconds on, is really the issue about volunteerism. The bill makes mention of it, but not as thoroughly as we perhaps would want because, certainly, in my organization we have two paid coordinators and probably about 300 volunteers providing the service of transportation and assistance to people in the community. If we do not think about the fact that the manpower, if you will—pardon me, personpower—of that 300 is vital to actually providing the service and if we forget that, then when we create the system looking for those people to provide the service and we've not involved them in the discussion, if we also think their loyalty to the organization from which they serve is transferrable to something that they may see as a government agency, then we have some difficulty.

The Ontario Community Support Association is very concerned about the lack of a full volunteer management system taking into account aspects concerning recruitment, placement, evaluation of the volunteer service, recognition of their service etc, the kinds of things that traditionally exist in our community services anyway. That's an area of concern we just want to underline very clearly.

Thank you, and I think we have two minutes for questions.

0950

The Acting Chair: Thank you very much for a very thorough and clear presentation. We have actually just a few minutes for questions.

Ms Jenny Carter (Peterborough): I'd just like to carry on with the issue of volunteerism and, of course, we are very much aware that volunteers make a tremendous contribution in this field and we want them to continue to do so. We have tried to continue this by giving a community-based board for each multiservice agency. The planning process is led by the district health councils, not civil servants, and there is a joint working group with the Association of District Health Councils of Ontario and the United Way, so we really want this whole thing to be community-driven and responsible to the community.

Could you give us some ideas as to what more we could do to keep this tradition of volunteerism going?

Ms Brennan: I think the issue is that the bill only makes mention of recruiting the services of volunteers. It doesn't talk about a volunteer management system. Certainly, what you've described in terms of activity—I believe firmly that the local entities will plan to include volunteers in an integral way. I believe that intuitively.

The bill somehow, though, doesn't really lay it out as strongly as I would like to see in terms of a management system that also includes the funds to manage that piece of the system. With such a thin statement inside the bill it's just not firm enough to convince me that there will be a real system to help volunteers make the transition and also to continue to do the service that you're describing.

The Acting Chair: Thank you very much for your presentation. Our time is up. If you have any additional information, please feel free to communicate with the committee in writing. All of the information that you send in to the committee will become part of the official record of the committee.

ST ELIZABETH VISITING NURSES'
ASSOCIATION, HAMILTON-WENTWORTH
VISITING HOMEMAKERS ASSOCIATION
OF HAMILTON-WENTWORTH
VICTORIAN ORDER OF NURSES,
HAMILTON-WENTWORTH BRANCH

The Acting Chair: I'd like to call the next presentation, St Elizabeth Visiting Nurses' Association, Hamilton-Wentworth; Visiting Homemakers Association of Hamilton-Wentworth; and Victorian Order of Nurses, Hamilton-Wentworth. Please come forward. If there are not enough chairs, just pull one up. As many people who would like to come and sit at the table and participate are welcome. I'd ask that you begin your presentation by introducing yourselves to the committee.

Mr Ken Bistrovich: Good morning, Madam Chair and committee members. My name is Ken Bistrovich, board member for the Victorian Order of Nurses, Hamilton-Wentworth. It is indeed my pleasure on behalf of the St Elizabeth Visiting Nurses' Association, Hamilton-Wentworth, the Visiting Homemakers Association of Hamilton-Wentworth, and the Victorian Order of Nurses, Hamilton-Wentworth, to have the opportunity to present our joint submission regarding Bill 173 to the standing committee on social development.

I am pleased at this time to introduce to you some other members of the joint committee who are seated at the table today: Mr Mike Pennock, Visiting Homemakers Association of Hamilton-Wentworth, board member; Ms Bernice King, St Elizabeth Visiting Nurses' Association, Hamilton-Wentworth, board member; Mrs Betty Muggah, director, Hamilton-Wentworth home care program; and Mrs Rita Soluk, president, St Elizabeth Visiting Nurses' Association, Hamilton-Wentworth.

My remarks to you today are a synopsis of our written submission which you will find in the folder that you have received. For your information, I intend to touch on who we are, the purpose of our presentation, our approach to reform, and our response to Bill 173. I expect our presentation will take about 10 minutes and will leave us approximately 10 minutes for questions and answers.

There are two accompanying background documents in the folder. These have been jointly prepared by our three agencies and in essence outline our proposed model for the provision of integrated community-based services and the progress that we have made to date in moving towards the integration of our operations. Those docu-

ments are dated May 1994 and July 1994.

At this point I would like to give you a brief background of who we are and the purpose of our presentation. Collectively, St Elizabeth Visiting Nurses' Association, Victorian Order of Nurses and the Visiting Homemakers Association are the major not-for-profit providers of visiting nursing, homemaking, case management and therapies in Hamilton-Wentworth. The Hamilton-Wentworth home care program and the placement coordination service are administered by the Victorian Order of Nurses.

Our combined services in the fiscal year 1993-94 represent approximately 90% of the total provincial expenditure in Hamilton-Wentworth for community-based health and personal care services.

In addition, our agencies provide a wide range of community support services, including Meals on Wheels, care giver support, a day program and volunteer visiting, which collectively involve over 1,100 volunteer service providers.

The purpose of our submission today is to urge you to reconsider the wisdom of full amalgamation of agencies to achieve the government's goals and to amend the proposed legislation, Bill 173.

Our approach to reform: In January 1994, the boards of directors of our three agencies formed an interagency task force with the following objectives: (1) to identify opportunities for integration of the current operations of our three organizations which are consistent with the provincial guidelines for the establishment of multiservice agencies; and (2) to prepare a model for the provision of integrated community-based services for submission to the district health council long-term care committee.

At the same time as we have formalized the relationship among our three boards, we have been collaborating with the coalition of the other community agencies in Hamilton-Wentworth which provide a range of community support services. Together, we are working towards the development of an integrated service system in Hamilton-Wentworth. Our work together has been undertaken in the spirit of a long-standing approach to interagency collaboration in planning and service delivery in Hamilton-Wentworth over many years.

In May 1994, the boards of directors of St Elizabeth Visiting Nurses of Hamilton-Wentworth, the Visiting Homemakers Association of Hamilton-Wentworth and the VON Hamilton-Wentworth developed and submitted a joint proposal to the Hamilton-Wentworth District Health Council outlining our shared vision of an integrated community-based service system in Hamilton-Wentworth. As well, we have committed ourselves to achieve greater integration of our operations.

In light of the expectations for change and in an effort to build on our strengths, St Elizabeth Visiting Nurses' Association, Visiting Homemakers Association and the Victorian Order of Nurses believe that the citizens of Hamilton-Wentworth would be well served by a region-wide integrated system for the delivery of health and personal care services, a system which:

- (1) Provides integrated region-wide intake and screen-

ing of individuals through direct client access to a single regional telephone number or local access through identified intake points which are electronically linked to the region-wide system.

(2) Employs a common assessment tool for all service providers and a streamlined assessment process in relation to the client's priority needs.

(3) Provides region-wide integrated delivery of case management, nursing, homemaking and therapy services organized in multiple interdisciplinary teams which may be located in satellite or neighbourhood offices throughout the region and linked with locally administered home support services.

(4) Maintains a dedicated case management service in each of the area's hospitals to support early access and transition from hospital to home.

(5) Maintains the availability and identity of locally initiated community-specific services which are linked with the region-wide services.

(6) Maintains the level of volunteer commitment which has sustained community agencies in both governance and service delivery.

I want to now turn your attention to focus specifically on our response to Bill 173. At the outset, we want to stress that we are committed to the principles and ultimate goals of the government's long-term care policy. We strongly support the need to improve and simplify access for the consumer to a full range of health and community support services in the community. We also endorse the determination to enhance consumer participation in decision-making and to ensure accountability of the provider for excellent care and service within the community.

1000

We are committed to taking leadership in constructive change. However, we have very real concerns regarding both the pace of the change and the determination of the government to implement a new structure whose efficacy and cost-effectiveness have not been demonstrated in Ontario or elsewhere in Canada.

We believe from our experience in working together to develop an integrated multidisciplinary client team that it is possible to achieve the outcome which the government is committed to through a federated model of organization rather than the amalgamation of agencies, as the government's Bill 173 requires.

From the client's perspective, the urgent need is for integration at the level of service delivery and simplified access to needed services. Whether the actual service providers come from one agency or multiple agencies is irrelevant to the client as long as they work together as a team with shared values, common assessment and shared protocols and standards of service. Our challenge, as service providers who have demonstrated our commitment to working together to provide high-quality, responsive service, is to develop the necessary governance and organizational structure to make that happen.

With respect to the organizational and governance structures, there has been no clear demonstration or evidence to show that amalgamation or consolidation of

service providers in a single agency will result in improvement in services. On the contrary, there is evidence that the administrative costs associated with amalgamation may further erode the resources available for direct service to the client and may negatively impact on quality and the volunteer base of many of the services.

It is for these reasons that we must express the deep concern of our three organizations about the proposed direction of long-term care reform, specifically, the creation of the multiservice agency as defined in the legislation. We are opposed to the government requirement for a full amalgamation of long-term care services. We ask that the standing committee on social development support our request for flexibility by amending Bill 173 to allow for the evolution of locally determined community models for long-term care services.

In closing, on behalf of the three boards and my colleagues here today, I want to thank you for the opportunity to speak with you. We welcome your questions and comments in response to our remarks or any of the other documents that we have submitted to you today.

Mr Jim Wilson (Simcoe West): Thank you very much for your presentation. I note on page 16 of one of the background papers called A Model for the Provision of Integrated Community-Based Services in Hamilton-Wentworth, of May 1994, there's a schematic on that page that I think best represents to me and perhaps most of the public what the original intent and vision of an MSA and one-stop shopping was. I think you've got it right. It's the first time I've seen it and I appreciate the schematic.

The problem is, the government has taken what was a relatively simple idea of one-stop access—perhaps that went as far as, certainly, information, perhaps assessment intake, referral to other agencies and certainly one phone number in each area, which was the most important thing that we heard throughout the public consultations—they've taken that and decided that the agency, the MSA, will have a monopoly also on the delivery of services after—in many cases I'm sure it'll take the four years to reach the 80% of delivery of services.

I just want to simply ask you, because it sounds like you've already gone 100 miles on your journey towards integrating services here—and cooperation, it sounds like it's been very good in the region. How problematic is the new MSA going to be for you? What are you going to do to try and preserve the identity of your agencies now, because they're going to take over governance and delivery of services, and I think it's the end of your agencies if this bill is allowed to pass as is?

Mr Bistrovich: Yes, exactly that. That is our point. What we're looking for is to get some flexibility in the system so that we as agencies can explore various opportunities and other options that perhaps may be available to us to deliver the kind of service the citizens and the community of Hamilton-Wentworth expect.

The Acting Chair: Do you have anything further?

Mrs Betty Muggah: Perhaps an additional point or two there. We're not saying, as we go through this journey, that ultimately in a community like Hamilton-

Wentworth there may not be some amalgamation and may not need to be some amalgamation, but what we're seeking is some permission to allow that to evolve over time. We have just begun a very active dialogue in our community—the three agencies that we represent with our sister agencies that are providing a range of community support services across the region—and we believe that we may be able to come up with some kind of a governance or organizational structure that will provide the kind of accountability the citizens of Hamilton-Wentworth require.

The problem is that the legislation introduces a four-year time limit, it introduces a restriction with respect to a 20% purchase of services, and it seems to imply, as we have worked it through, that ultimately in order to meet the requirements of the legislation we really would have to amalgamate to form this one agency, all of us, that provides this core basket of services.

We're asking for some flexibility so that the organizational arrangements, the governance structures, will allow us to customize the appropriate kind of structure for Hamilton-Wentworth. The legislation doesn't allow us to do that.

Mr Mike Pennock: Just another quick comment: I think the key message we're trying to bring to you today, and it's a Hamilton-Wentworth message and we don't pretend it's a provincial message, is that we have already gone a long way along the road to integration here. As you heard, 90% of the services are already being provided through three agencies, but they are three agencies that have their own stature and history and status in the community, their volunteer base, their donor base. And we can go further on the integration, as we say we're doing, but we think what we have represents the best of both worlds.

You can integrate, you can coordinate at the service end but still maintain and build on the history of strong agencies in the community, and the possibility to continue developing that kind of model is what we're really asking for. We're not saying this is a model for the rest of the province—what works in Kingston or what works in Kitchener may be quite different—but we're absolutely convinced, because it's evolved here already, that it is the best model for Hamilton-Wentworth and we're looking for the flexibility to continue evolving it here.

Mrs Barbara Sullivan (Halton Centre): Certainly Hamilton-Wentworth is known to be a model and to reflect the kind of collaborative and cooperative and coordinated efforts between the agencies here. One of the things that will be clear is that, if an MSA comes into place, your agencies will ultimately disappear. There will not be the critical mass for the VON and for the Red Cross—although not in this presentation—and will certainly disappear, St Elizabeth and so on.

The volunteer core that supports these organizations is key in two ways: one, in service delivery; and secondly, in fund-raising for the organizations themselves. I understand that about 30% of income from many organizations is a direct result of volunteer activity.

Could you give us an impression of whether you think your volunteers would shift their allegiance to a more

bureaucratic single agency that doesn't have the history and the cultural ties of your organizations.

1010

Ms Muggah: We're having a little debate here about who's going to take that. I can speak from a VON perspective. Our VON here in Hamilton-Wentworth has approximately a thousand volunteers. We've been very successful in recruiting, attracting and maintaining those volunteers. They're a critical part of three for sure, three anyway of our key programs, Meal on Wheels, VVP and care giver support.

We are extremely concerned about the need to ensure that the volunteer service sector continues to grow, and I think we'd have to say to you that without clear evidence on the table, we're very, very reluctant to move towards a multiservice agency model that could sabotage or restrict our volunteer growth in the future, and we just haven't seen the evidence. Perhaps a further comment from St Elizabeth's.

Mrs Rita Soluk: Probably just a short comment I would make is that we could illustrate by example here in Hamilton something that happened with the cancer society. They had an office on the mountain which they made a decision they would close. When they announced that decision, the volunteers were quite clear they would not be prepared to provide their volunteer support down the mountain and, in fact, when they closed the mountain, they lost their volunteers. Not only that, it's my understanding that when the Terry Fox run was held that year following the closure, they did not do as well in their fund-raising activities as they had done in previous years, and they felt that was the result of some of the anger they were still experiencing as a result of closing their office.

So if you're looking at the results just within a particular organization with the same mission and same values, and they weren't prepared to move down the hill within the same region, I think that tells you what sort of support we might expect from the volunteers if we pursue this line of action.

The Acting Chair: Thank you very much for your presentation. We appreciate your coming before the committee today and if there's any additional information you'd like to share with us, please feel free to submit it in writing to the clerk.

JACQUELINE BALFOUR

The Acting Chair: I'd like to call Jacqueline Balfour. Please come forward and introduce yourself to the committee. You have 20 minutes for your presentation.

Ms Jacqueline Balfour: Good morning. My name is Jacqueline Balfour. I'm a registered nurse with 23 years' experience. My work experience includes 17 years of hospital nursing and for the last six years I have been employed by the regional Niagara home care program as a case manager.

I can assure you that I applaud this government's efforts to improve services in the home and reduce reliance on institutional services for the people of Ontario. I have firsthand knowledge that people are happier and do well at home with the right mix of services to meet their needs.

I have seen and am seeing more flexibility even within the current home care program to be more responsive to the deficiencies which will ultimately be addressed by long-term care reform. I have been closely following the process and documents that have been evolving and am pleased to be able to comment today on Bill 173.

I am pleased to see that the bill has captured the essence of what I believe the home care program has been and is continuing to do, and that the following aspects have been recognized as important and have been enshrined in the legislation.

These include page 10, clause 7(1)(b), which will ensure "competence, honesty, integrity and concern for the health, safety and wellbeing of persons receiving the service"; on page 13, subsections 14(1) and (2), which reflect the current practice of providing consumers with information about available services and the referral to other available community services which are not necessarily provided by the agency; page 15, section 20, which refers to the development of service plans based on assessment and eligibility with the review and revision of the plan as requirements change.

I can only hope that case managers will continue to provide these components in the current format of face-to-face encounters with consumers. The old adage that a picture is worth a thousand words is especially true in the assessment process. Eyeballing someone in their own home can show and tell so much.

Often someone who will tell you that they can manage will finally feel comfortable enough, when you've put them at ease and built a rapport, to admit that it takes the better part of the morning to get washed and dressed and as a consequence they have to lie down and haven't the energy to prepare their breakfast. Can this be captured in any way other than a home visit?

You would also be amazed at what people will open up and tell you when they know you are a nurse. Also, it is only on a subsequent home visit a month or three months later that you can be amazed at how much brighter they look once services are in place, or recognize the decline in their walk and suggest a physiotherapy visit to try a cane.

With respect to part III, the bill of rights, on pages 7 and 8, I initially could not understand the necessity of its inclusion in light of the fact that nurses and therapists are regulated health care professionals who are governed by their respective colleges. Protection of the public is the legislated mandate of the colleges and ensures that all this section describes happens. However, upon further deliberation, I realized that this section must seek to ensure that unregulated workers are answerable and accountable. I hope this is the intent, and that it is not the result of a perception that current practice does not respect consumers' rights.

On page 9, subsection 5(1), and page 24, section 40, these sections address the immunity from liability for the director or a program supervisor and the appeal board. I must comment that I can find no similar proviso to acknowledge that all service providers will have any form of protection against acts done "in good faith in the execution or intended execution of any duty, function,"

and I believe this must be incorporated into the bill.

I believe that the appeals process outlined on page 22, part IX, will be welcomed by service providers as well as consumers, for I have never relished advising anyone that they do not meet eligibility criteria. It is reassuring to know that there will now be an easily accessible mechanism for resolution, or at least a confirmation of what's happened, from the higher authority.

I have grave concerns about the practical application of the order to suspend or cease activity on page 28, section 47. Even though subsection (4) on page 29 attempts to waive the hearing, leaving the authority to suspend or cease activity to the Minister of Health, in my view, sets up a bureaucracy which could take at least days.

This section acknowledges that "the continuation of the activity is an immediate threat to a person's health, safety or wellbeing," yet still leaves the authority to suspend or cease with the Minister of Health. When any worker feels for their safety, there needs to be assurance that service is suspended, period. Also, that service does not restart until an investigation has been concluded and remedies are in place. Even if it is not a crisis situation—if, for example, a homemaker agency reports a loaded gun in the home—I believe there is an immediate obligation to suspend service until the matter is investigated and resolved, not to continue service while you seek an order to suspend through ministry channels.

Page 38, paragraph 30, speaks to the service providers having "certain qualifications" or meeting "certain requirements." This seems much too broad and lacking in clear direction in a document which is so specific in so many other areas. It is no secret that we expect to see a proliferation of personal support or generic workers and, as a cost savings, less reliance on professional service-providers, but such a nondescript reference leaves, in my view, too much to chance in ensuring that consumers receive care and service from qualified, trained individuals who are not functioning beyond their scope and without the capacity to recognize reportable or noteworthy observations.

1020

I would be less than honest if I did not admit that I am fearful for my future work, life and job security. I believe that for consumers who made the deficiencies in the current system known to government during the consultative phase, case management bore the brunt of being misunderstood and oft-times blamed for the deficiencies. I see nothing in the bill which verifies earlier documents which indicated that home care staff will form the core staffing of the MSA. I see nothing that ensures the consultation with unions or successor rights with a move to MSAs that was referenced previously.

I can assure you that home care programs have been fiscally responsible and budget-conscious and always cognizant of the most cost-effective means possible in service delivery, but I am fearful that the consumers we have consulted have unrealistic expectations of just what the government will provide under the guise of assisting people to remain in their own homes.

I hope we do not get into the business of cutting grass

and shovelling snow with dollars that should be spent for health services. Currently, the integrated homemaker program has a capped budget and we know that the day will come when people are wait-listed. And I note that on page 16, subsection 21(2), the document also speaks of the waiting list for service.

Life experience dictates that it's the squeaky wheel that gets oiled, and it is not the informed, knowledgeable, active senior that I am worried about, but rather the timid soul who has always made do and never asked for help. I wonder whether they will continue to fall through the cracks even in this new revamped system.

Thank you for this opportunity to share my thoughts with respect to Bill 173.

The Acting Chair: Thank you very much.

Mrs Sullivan: Thank you. You've put a lot of work and analysis into the presentation, and I think members of the committee appreciate that. As a consequence, you've covered a lot of areas that I'd like to ask you questions about, but I know the Chair is going to keep me in line.

One of the questions I wanted to ask relates to other interventions that we've had where case managers have suggested case management should be included as a profession in the professional services category. I'd like your comment on that.

I'd also like your comments on whether the work of the MSAs should be accredited in some manner such as might be done through the Canadian Council on Health Facilities Accreditation or some other similar review board or agency, and in particular the paraprofessionals and non-regulated workers—how their work would be evaluated.

The third thing: You mentioned at the very end the successor rights and union representation. One of the concerns I have particularly is that more than half of our community support workers and home workers are in fact non-union and there is absolutely no guarantee that they will find jobs. In fact, union members, because of the Labour Relations Act, have indeed a greater protection than non-union workers, and clearly there's a bias in the setup of the organization towards a union member.

I know they're larger questions, but you can decide which one you want to tackle before she cuts you off.

Ms Balfour: Okay, I guess really—

The Acting Chair: Just to clarify, I never cut off deputants, I always cut off members.

Ms Balfour: I guess, having had the opportunity to give a pitch for case management, that would be my first choice to respond to of all the concerns you've raised.

Certainly in Niagara, we have the experience of being all registered nurses who are case managers. I feel that we bring tremendous assessment skills as well as our professional judgements, knowing health issues and being able to have a unique perspective to look at whole human beings and a holistic approach.

Certainly it was a real eye-opener to me, when I moved from hospital into the community, that you suddenly saw people as human beings in their own

environment. We see ourselves much like quasi-detectives. So much you can see that isn't said; in the fact that maybe the dusting hasn't been done and there's a lot of clutter, even though someone will say, "Oh, I'm managing just fine." You can sense tensions between family members and, again, with getting a rapport, try and pull out the kinds of things that hopefully you can glean about the relationship and how it's impacting on health and the situation.

One of my biggest fears, as we've been moving through this initiative, is in hearing that the government, in its quest for consistency—which is needed; I'm not against consistency—is looking very much at an assessment tool. We were told, at a case manager's conference, that the tool was going to be colour coded and people could essentially do their own assessment and send it in. This is, I think, the part that is most frightening because I again fear for these frail people who, seeing a colour-coded, half-inch document would simply be overwhelmed and never proceed.

Mr Gary Malkowski (York East): Thank you for your presentation. Your feedback is most important for us. We're aware of some of the issues that you have already brought. You also mentioned you are concerned that some service providers may not get jobs, but my understanding is that a lot of the service providers who are working now will be absorbed by the MSAs.

You also talked a little bit about case managers being blamed for some of the misconceptions, or at least some of the problems up there, but what's true is some people do make mistakes. That's true. But do you truly believe that the system itself, systemically—that giving consumer feedback, how we could improve the quality of service among all professionals working with the consumers to make sure that no one feels threatened. How would we go about doing that in long-term care so that consumers feel their rights are protected and that the staff feel they are in a comfortable situation where they can do the best they can, given that people do make mistakes? Based on your experience, how could those kinds of problems be avoided in the future?

Ms Balfour: Actually, I do believe that in having the bill of rights in the document and in building on what is current practice, there's no danger that we won't achieve these ends. Certainly, it's practice now to set up, on that first assessment visit as a case manager with your client, just what mix of services will suit and fit in best.

We can't always give people exactly what they want—expectation does not always mesh with need—but we do our best to be creative and I can honestly say in my practice and certainly in viewing the practice of all, if not most, of my colleagues, that we are very cognizant even now in current practice of making the client, the consumer, and his family very much feel a part of the process, and very much we want to be approachable when they're having difficulties, when needs change and when they're in need of reassessment.

The Acting Chair: Thank you very much, Jacqueline. We appreciate your coming before the committee this morning. If you have anything further that you'd like to communicate with us, please feel free to do so in writing.

1030

ST JOSEPH'S HEALTH CARE SYSTEM

The Acting Chair: Our next presentation is St Joseph's Health Care System. I invite you to come forward. Welcome. You're not strangers to this committee nor to myself. A personal hello.

Sister Joan O'Sullivan: How do you do?

Thank you very much for the opportunity to respond to Bill 173. My name is Sister Joan O'Sullivan and as the vice-president of St Joseph's Health Care System, I am here on behalf of Sister Teresita McNally, president and chair of St Joseph's Health Care System.

My past experience includes time spent as CEO of two hospitals of various communities within the Hamilton diocese. With me are Mr Brian Guest, executive director of St Joseph's Health Care System, Sister Margaret Myatt, president and CEO of St Joseph's Hospital and Home, Guelph, and Mr Paul O'Kafka, executive director of St Joseph's Villa, Dundas.

My comments will deal mainly with the implications for community-based services provided by our member facilities. Please understand that the development and governance of community-based services are an integral component of the historical and continuing contribution of St Joseph's Health Care System to the communities we are privileged to serve.

St Joseph's Health Care System was incorporated in 1991 and represents a consolidation of the health care ministry of the Sisters of St Joseph of Hamilton which has provided health and social services to the communities in the Hamilton diocese for over 130 years. Our health care ministry is governed through volunteer representation from our communities on local boards of trustees and encompasses programs and services offered by the following member facilities: St Joseph's Hospital, Brantford; St Joseph's Villa, Dundas; St Joseph's Hospital and Home, Guelph; St Joseph's Hospital, Hamilton; St Mary's General Hospital in Kitchener.

As you can see, we are well represented in both the long-term and acute sectors in delivering care. Our mission reflects our Judaeo-Christian values and emphasizes our respect for the dignity of all persons, regardless of age, race, religion or infirmity.

The primary concern that brings me here today is with the proposed scope and governance implications included in Bill 173 with respect to community-based services. My understanding of the proposed multiservice agencies, the MSAs, is that they will, de facto, take over the governance and administration of community-based programs for the elderly in the province.

Specifically, for St Joseph's Health Care System, this would mean the dissolution of such programs as the seniors centre and respite care program at St Joseph's Villa, Dundas, and the Alzheimer day program and the Out and About program at St Joseph's Home, Guelph. I am also unclear as to the government's longer-range plans for other community-based programs, such as the women's detox program administered through St Joseph's Hospital, Hamilton, or the alcohol and substance abuse program through St Mary's General Hospital, Kitchener.

Let me state clearly and unequivocally that we support continuing efforts to coordinate and expedite access for seniors to long-term care programs and services in the community. We also support efforts to standardize funding, the development of critical evaluation and outcome measurement tools and strategic planning.

We have grave concerns, however, that this legislation as it is currently proposed will effectively eliminate the contribution of volunteers and staff who have developed programs and services for seniors in response to identified community needs. We also submit that a shift in governance and administration to a government-controlled bureaucracy, the MSA, will not necessarily be cost-effective nor more responsive to community needs. It is unrealistic to think that one can dismantle a system which has been in place for so many years and reassemble it under a new governance and administrative structure. Health care is not conducive to a cut-and-paste approach to delivery.

There is also the critical element of choice for seniors missing from this proposed structure. For example, if seniors do not feel they are receiving adequate or appropriate care through the MSA, are they at liberty to seek help elsewhere? Will it be available and at what cost? These are real issues which seniors are expressing to us, related to this proposed legislation.

The rationale for our position is as follows:

Tradition of Care: As I have pointed out, we have a long-standing tradition of serving seniors in our community with both residential and community-based programs.

For the last several years, health care facilities have been challenged by the governments of the day to develop community programs as an alternative to institutional care.

We have responded to this challenge and now offer a continuum of care which provides support for both families and seniors. For example, at St Joseph's Villa, Dundas, we provide outpatient care through our seniors' centre, short-term relief for families through our respite care program and, if necessary, facility-based care. This continuum allows seniors and families to plan their future care in cooperation with staff they know and trust.

Last week, during the review by the Canadian Council on Health Facilities Accreditation, at the Villa in Dundas—that is a third-party review—the following comment was made: "You are to be congratulated on lobbying efforts with government and insight into providing a continuum of care—such as estates, day centre, respite and permanent residency at the Villa. Seniors come here experiencing commitment and trust."

We feel it would be a major step backwards to isolate health care facilities such as St Joseph's Villa, Dundas, and St Joseph's Home, Guelph, from providing community-based programs as part of their mission to their communities.

Economics: St Joseph's Health Care System is a major corporation in the health care industry with a combined annual operating budget approaching \$300 million. Our community-based programs benefit tremendously from the economies of scale which exist, ranging from pur-

chasing power for supplies to insurance to administrative support.

Simply put, we feel that we operate as responsible stewards for the taxpayers of Ontario, in an effective and efficient manner, and have taken advantage of opportunities for administrative efficiencies.

Volunteerism: The role of volunteers is critical in the delivery of our community-based services, ranging from governance to direct care and support. Our boards of trustees and board committees are all volunteers who are selected from a cross-section of individuals in our communities who are committed to our mission and the care of seniors. Also, the many members of each of our facility volunteer associations respond to our mission and are a key component of all our programs and services, including those that are community based. This tradition of volunteer support is not, in our opinion, easily transferable to a government bureaucracy and would represent a tremendous loss to the seniors in our communities.

1040

Quality of care: Our facility-based community outreach programs are governed and accountable for the highest level of quality care. For example, all of our community-based programs are reviewed regularly by board committees including medical, nursing and community representation and are subject to regular external reviews through the Canadian Council on Health Facilities Accreditation. In our opinion, the quality of care delivered is of the highest standard and would not be enhanced in any way by a change in governance.

In conclusion, we support efforts to coordinate and simplify access to programs and services for seniors, but we do not support a radical change in the governance and administration of those same programs and services which have served our senior population with commitment and excellence.

Without question, we are all striving to find models to deliver the best possible care for seniors in Ontario, but we implore the standing committee to recognize the tradition and mission of existing care givers to this end.

Mr Larry O'Connor (Durham-York): I appreciate your coming before us today. I noted on page 5 of your brief, you mentioned the size of the St Joseph's Health Care System; indeed with a budget of \$300 million, it is a major corporation. Yet when we take a look at—locally, I think the home care budget here is around \$30 million. So it's a little bit lower community based when it comes to that.

I was just wondering, we've heard through our hearing process, the consumer appeal process might be too cumbersome and problematic for some of the consumers who may find difficulty in the evaluations that they had. In a corporation the size of the St Joseph's Health Care System, how do you deal with an appeal process to make sure the consumers' needs are met and work with consumers in that area?

Mr Brian Guest: I'll answer that, if I may. All of our boards are represented by community members. About five years ago, we started advertising in all our community newspapers for people who are interested in joining

our boards. Actually, we'll now start a system where people will join our board committees and eventually join our boards, so we think we are very well represented and in touch with our community.

In addition, in the long-term care sectors we have residents' councils which regularly provide feedback. We have meetings with relatives, and I think we really go to tremendous lengths to involve consumers through accreditation processes. We're subject to these accreditation processes we talked about. We do regular audits of satisfaction I think of the most formal nature possible. I really believe we have identified exactly what you're talking about as a key component.

You also must remember that all of our communities have their own boards of trustees and they are representative of those specific communities, so it's not a top-down head-office governance model in any sense.

Mr O'Connor: In looking at our—

The Acting Chair: Only one question, Mr O'Connor. Thank you. There are a lot of members who would like to ask questions.

Mrs Yvonne O'Neill (Ottawa-Rideau): I'm really delighted that you came this morning. Your reputation precedes you, not only in your community but beyond. We have the very same concerns you have. I'm going to ask legislative counsel or the director to try to explain to us just how facilities such as yours that not only are evaluated in their communities but beyond that, through the accreditation process, are now going to fit into this whole Bill 173.

You have already gone through Bill 101. Now how do we put Bill 101 and Bill 173 in a situation such as yours? Your services cannot be lost. Maybe someone will be able to help us.

The Acting Chair: Are you requesting a reply from the ministry?

Mrs O'Neill: The parliamentary assistant, yes.

Mr Paul Wessinger (Simcoe Centre): I'll ask Mr Quirt to respond to that.

Mr Geoff Quirt: Thank you. In specific answer to the question, the programs and institutional services offered at the hospital level and at the homes for the aged level would not be directly affected by Bill 173. In other words, the corporations that are now responsible for governing the—St Joseph's Villa, for example, would continue with that responsibility. We are now working with St Joseph's Villa to determine the extent to which it should be involved in the respite care business, providing respite care services to the community at the facility level, and that funding would be flowed directly to the facility and would not be affected by Bill 173.

The extent to which the organizations are involved in the delivery of other community-based services, like Meals on Wheels or transportation, those services would certainly form part of the services to be discussed locally at the district health council planning subcommittee: how best to bring together those programs and services under the MSA umbrella. Of particular concern to St Joseph's Villa, and I'm speculating here, might be the future of its in-house day program.

We have heard from other facility-based operators who have had similar concerns that the day program forms an integral part of their long-term care facility operation. Obviously, St Joseph's Villa and other facilities like it are heavily involved in the community and the bill, as it currently stands, would allow for the continued operation of that program at a facility level within the 10% or 20% purchase limits the MSA might have. It's conceivable that we would consider an exemption of those facility-based day care programs if in fact the committee hears similar concerns raised as we go across the province.

I suspect that may be a position put forward. The government has already indicated that programs independent of facilities that offer social-recreational activities, elderly persons' centres, could remain separate from the MSA if in fact the local planning process were to come to the conclusion that this is the best thing for that community.

Mrs O'Neill: Thank you.

The Acting Chair: Thank you for your presentation. You'll be on first questioner with the next deputation, if that's all right, Mr Jackson, or if you're—

Mr Cameron Jackson (Burlington South): Can I call them back to answer it then?

The Acting Chair: There's about one minute. All right?

CANADIAN RED CROSS SOCIETY,
ONTARIO DIVISION,
WEST CENTRAL AND CENTRAL REGIONS

The Acting Chair: I'd like to call the next delegation from the Canadian Red Cross Society. Welcome. Please begin your presentation by introducing yourselves to the committee.

Ms Heather Richardson: Good morning. We're pleased to have this opportunity to speak to Bill 173. I'm especially delighted to introduce you to two volunteers.

At this point, I would like to share with you that I am Heather Richardson and I am the regional director for the Red Cross homemaker program in west central Ontario. West central encompasses Hamilton, Wellington, Niagara, Brantford, Waterloo and Halton. I also want to indicate that I have been part of the Red Cross management team for almost five years and I truly believe in the work of the Red Cross and in the work of the homemaker and home support programs. I am proud of the staff and volunteer work in assisting vulnerable people in west central Ontario.

The two people at my side, Della Crozier and Diane Pick, are valued volunteers and they're going to share a little bit about themselves. First of all, we're going to begin with Della.

Mrs Della Crozier: Good morning, Madam Chairman and panel members. I've always considered myself a community person, interested in and caring about what is happening to my neighbours, my friends and my community. Since moving from rural Middlesex county to the rural Milton community seven years ago, I have become involved in my new community. I am a member of the Halton long-term care committee, one of seven that represent the "other" category.

I am also on the Halton Placement Coordination Service board of directors and for the past four years I have been a Red Cross volunteer, the homemaker chairperson at the Milton Red Cross branch.

1050

Ms Richardson: I'd now like you to hear a few words from Diane about her portfolio and then the two volunteers will jointly give the presentation.

Ms Diane Pick: As an illustration of how well the Red Cross utilizes its volunteers, I presently perform four functions with them. I'm the vice-president of the branch, I'm the west central homemaker area representative, I'm the home support representative on the regional council and I sit as a member of the homemaker services committee in Brantford.

The reason I'm willing to give all of these hours to the Red Cross is because I also believe they provide critical services to vulnerable populations. Their seven stated fundamental principles of humanity, impartiality, neutrality, independence, voluntary service, unity and universality are principles that are demonstrated by their staff and volunteers on a regular basis. It's an honour and a privilege to be able to volunteer with the Red Cross.

Mrs Crozier: The Red Cross is a symbol in our communities of people helping people. We all know of the Red Cross international work throughout the world. However, I have come to appreciate how unique, caring and committed the Red Cross organization is in our own community.

The Red Cross depends on staff and many, many volunteers who give generously of their time to provide a wide range of programs and services, such as transportation, equipment loans, first aid, seniors' programs, Meals on Wheels, blood clinics, homemaking, fund-raising for local projects, as well as international famine relief aid to war-torn countries and other disaster aid. The volunteers also give many hours in committee work to this organization.

Homemaking is the core program of the Red Cross community support services. It is a staff-employed service with volunteers involved at a board level. The homemaker service provides personal care, family relief and home management to all ages. This includes individuals and families in time of illness, convalescence, disability and family crisis.

Homemakers help the frail, elderly and disabled with a variety of services during each visit to the home. For example, homemakers might do a morning bath, get the individual dressed, prepare, serve and clean up breakfast, then clean up the bathroom area and tidy up the bedroom and laundry. Their days are busy.

As the homemaker carries out these tasks, there is an opportunity for interaction with the individuals which meets the needs of their companionship. This helps the individuals maintain their independence and self-esteem and keeps them in their own homes as long as possible. It also prevents loneliness, isolation and neglect that can often occur as the individuals grow more frail and less able to do for themselves.

The Red Cross organization has 75 years of experience

in providing home support services in our communities. Over the past two years, Red Cross volunteers and staff at both the local and provincial levels have been participating in the process to reform the long-term care system.

The Red Cross, as part of the team delivering services, supports the need for change to the present long-term care system. A consumer-friendly system with simple access and coordinated services will make it easier for the consumer, the care givers and the families to find and receive the care and service.

This all sounds so simple. However, my experience this past year on the Halton long-term care committee has shown just how complex and difficult the task is to reform the present long-term care system. This has been quite an experience and it's hard work. I have some points that I would like to emphasize with you.

Flexibility: The legislation and the regulations need to be flexible for the individual communities to design a system that fits and responds to the needs of the community and builds on its strengths and resources. The list of services should be flexible so as not to be exclusive of the service needs in the future, and the communities need the flexibility to allow them to create a design that best suits their needs.

Consumer representation: The legislation needs to ensure consumer and volunteer representation on the boards of the organizations that the community creates. Otherwise, it will be easy for representation of the health and social service professionals to outnumber consumers and volunteers. In my work on the long-term care committee, the consumer and volunteer perspective has proven invaluable, adding another dimension to the discussions.

Volunteers: Our volunteers give many, many hours of service. They are committed to their clients, to the service they provide as well as to the organization they work with. We need this caring culture, and the committed caring culture we have now, to move into the new organizations that our communities will create. The loss of volunteer involvement will have a direct impact on the services delivered and on the funding available.

I am also concerned about the effects of the transition and the anxiety it creates for our volunteers and our staff. They both must be treated fairly. The human resource issues for volunteers and non-union staff are of critical importance and cannot be ignored. To date, we do not think we have had a satisfactory answer to our concern.

In summary, we need to ensure that the legislation and the regulations allow flexibility for our communities to design a system that responds to the community needs and builds on its present strengths and resources. All of us must work together in a cooperative and collaborative manner to make the changes necessary.

We thank you for the opportunity to present a Red Cross position on this important issue. Now I'd ask Diane to summarize the position of the Red Cross.

The Acting Chair: Did you want to make further presentation?

Ms Pick: If I could, please, I'd like to give an overview of the full Red Cross position. I believe the

position's been distributed. I'll just be doing a summary of that for you.

The Acting Chair: By all means.

Ms Pick: To understand the Red Cross position, you need to understand a little bit about our structure. The Canadian Red Cross Society is a member of the International Red Cross and Red Crescent movement. One of the fundamental principles of the movement states that there can only be one Red Cross society in any one country.

The society is a non-profit, charitable organization incorporated under federal law. Each province has a Red Cross division, but the divisions are not separately incorporated and are accountable, through the secretary-general, to the board of governors of the society. The Ontario division of the Red Cross operates 78 branches, almost all of which run community-based long-term care programs.

1100

Our programs have been developed in response to needs identified by the local communities. Particular emphasis is placed on ensuring necessary services are available to the vulnerable members of those communities. We often are the only service provider in sparsely populated and remote areas of the province.

Through our programs, we provide services to over 130,000 people. Our services include over five million hours of homemaking, almost half the homemaking service provided in the province. We also provide over 100 other community-based programs. Almost 10,000 volunteers and 6,000 staff, mostly women, together provide these services.

The Red Cross is supportive of the principles that have been developed for the reform of long-term care. However, there are some sections of the current draft of Bill 173, an Act respecting Long-Term Care, that are a concern to us.

Later in my presentation, I will make three suggestions for amendments to the legislation. We feel that any legislation must be flexible enough to allow service providers to meet the changing needs of their diverse communities. Legislation must allow us to work with other agencies in our communities to find new and more effective ways to provide the services and to make sure that the services we provide remain relevant.

We are particularly concerned that the legislation respect the history and traditions of volunteer agencies like the Red Cross. These agencies are part of their communities. Their services were created to meet needs in their communities, and often it's the volunteers who make the programs a reality.

Although we support the principles underlying the reform and the purposes as delineated in Bill 173, we are not able to support the creation of multiservice agencies as described in the act. We acknowledge the need for improved access to and coordination of the existing system, but we also see many good parts to the system we now have.

This proposed system will create a completely new organizational structure that is untested. The Red Cross operates services across the province. This big picture

allows us to identify some simple changes to the system that would increase efficiency and improve quality. We're very concerned that the system must not fail the vulnerable people who depend on these services.

The legislation, as it is currently drafted, precludes the Red Cross from becoming an MSA or providing services as part of an MSA. I earlier described the structure of the Ontario division of the Canadian Red Cross Society. The legislation's requirements that an MSA must be incorporated under Ontario legislation and that each MSA must have its own board of governors are incompatible with the fundamental principles and corporate structure of the Canadian Red Cross Society.

The Red Cross has three specific recommendations for amendments to the legislation. We believe that these amendments would respect the purposes of the legislation but make the legislation more flexible and allow us to use the strengths of the existing system.

The first is part II, subsections 2(3) to (7) inclusive. This section designates the community services which are to be provided by MSAs. The bill describes four categories for these services and outlines the specific services that fall under each category. We are most concerned about the division between "homemaking services" and "personal support services." We believe that this is inconsistent with the current practice and emerging future trends.

It has taken concentrated effort over the past few years to erase the belief that homemakers are not simply Molly Maids. The women, and I refer to them as women because the vast majority of our over 5,000 homemakers are female, have worked hard to have them become accepted as valued members of the health care team. Through formal educational programs, on-the-job training and adherence to a high standard of practice the homemaker has, for the most part, left behind the rather subservient role she played on the health care team. Homemakers are taking on increasing responsibilities that allow us to better use the limited funds allocated to community-based health care. Not long ago, the nurse was the only health care professional who could bathe a client. Now, a trained homemaker can perform this task.

The separation of the personal care versus non-personal care services is ambiguous and inconsistent with the way services are usually delivered in the client's home. Many functions routinely provided by homemakers cross the boundaries between what legislation classifies as "homemaking" and those called "personal support." One example: Training or assisting a client to plan nutritious meals, shop, store the food and prepare the meal is homemaking, while training or assisting the client in activities of daily living is personal support. The Red Cross feels that the high level of interdependent activities in the personal support category and those routinely provided by the homemaker must be acknowledged.

We recommend that this section of the legislation be changed to respect the role of the homemaker and that such specific detail be moved to regulations.

Part VI, section 13: This section stipulates that an MSA may not spend more than 20% of its budget to purchase community services. This requirement is not to

be administered globally but applies to each budget line for each of the categories of services. This is unlike the present system, whereby home care programs broker most of the services they provide, purchasing them from autonomous service provider agencies.

Presently, many services are provided effectively and efficiently by a number of established agencies with long histories of service to their communities. They are often supported and governed by volunteers who are part of the community. Stable relationships have developed between provider agencies, care givers and the individuals they serve. Rather than replacing the existing system, efforts should be made to improve coordination and enhance efficiencies.

In most communities, services are provided by several provider agencies. Each agency must retain a critical volume of service to remain viable. The volume of service must be adequate to support the operation if the agency is to stay in business. Where MSAs are declared as a move towards assuming 80% of a given service, the critical volume necessary for the alternative service provider to exist will be lost.

We recommend that this section of the legislation be changed to eliminate limits on services that may be purchased.

The Acting Chair: Five minutes remaining.

Ms Pick: Okay. I'm almost done. Part VI, section 15: This section allows the minister to exempt an MSA for up to four years from the provisions of legislation. The principles underlying the reform recognize the uniqueness of each community and support the community's right to determine the best way to provide service. However, if the communities are obligated to have MSAs, as defined by the act, in place within four years, they will be unlikely to pursue alternative ways to address the needs of their residents. The government has repeatedly stated that there is not to be a "cookie-cutter approach." This provision appears to be contrary to that statement.

We recommend that this section of the legislation be changed to eliminate the time limit.

We hope that the changes brought about by the long-term care reform will not preclude the Red Cross from continuing our over 75 years of providing services to our communities. We feel that the proclamation of the act, as it is drafted, will prevent the Red Cross and likely many other voluntary organizations from continuing to provide services that we have developed. We are committed to meeting the needs of the vulnerable members of our communities now and into the future.

Thank you for allowing us to make this presentation.

1110

Mr Jackson: I'd like to thank you for your presentation, because not only do you give three specific recommendations, but you set out very clearly a part of the contribution which the Canadian Red Cross makes in Ontario. I'm absolutely overwhelmed by page 5 of your written brief, which lists the variety of services you provide and tells us you're providing five million hours of homemaking and representing about half the total component of delivery in the province of Ontario. That's

absolutely staggering, and yet this legislation would propose to dismember you from those services at some bureaucratic discretion. On the second page, it talks of 130,000 individuals who are provided with service—10,000 volunteers and 6,000 staff. That's incredible.

My question is, are your staff aware of the implications of this legislation—that's a lot of people—and have they been given any kinds of assurances about how transition might work? And perhaps this is a terrible question for you: Do you have any kind of severance proposal or budgeting proposal for the hundreds and thousands of dollars in severance packages that will be required from staff when you dismantle some of these services? You know what I mean by that. You're not dismantling the whole Red Cross; you're dismantling huge components, and agencies within and services within. Have you budgeted for this, as one person called it, the sabotage of your staffing components?

Ms Richardson: I'm glad you asked the question. Certainly you've hit the nail on the head. The financial impact on the organization would be tremendous, and certainly the whole concern around severance does also relate, as you well noted, to assurances to staff. Of course, as it was made clear in the presentation, the majority of our staff are at this point non-union-based, and certainly it is our hope that all staff would be able to receive from the government some type of assurance that their services, because of their training and their experience, would be maintained through any transition. Certainly, this is something that we would request from the government, that there would be some work done together so that the organization itself would not remain encumbered by that type of responsibility.

ONTARIO MARCH OF DIMES,
NIAGARA REGIONAL OFFICE
AND HAMILTON REGIONAL OFFICE

The Acting Chair: I'd like to call the next presentation, the Ontario March of Dimes, Niagara region, and also the Ontario March of Dimes, Hamilton region. This is a joint presentation. Please come forward now.

Ms Maureen Lamarre: I'm Maureen Lamarre, from the Ontario March of Dimes that covers the Halton region, Hamilton-Wentworth and Brant county. I'm the independent living manager, which means that I'm responsible for all the programs that relate to attendant services in those three areas.

Mr Doug Overy: I'm Doug Overy, from the Ontario March of Dimes, Niagara region. I too am an independent living manager, supervising independent living programs in Niagara and Haldimand-Norfolk.

Madam Chair, respected committee members, the submission before you today is based on information contained in a written brief that will be or has been presented to the committee which outlines the Ontario March of Dimes stand on Bill 173 at the corporate level.

The Ontario March of Dimes commends the government of Ontario for its efforts to reform long-term care services in this province and to implement the multiservice agency concept.

The Ontario March of Dimes has a vital interest in the

reform process. The mission statement of our organization is, "To assist adults with physical disabilities to lead meaningful and dignified lives." We accomplish our mission through the provision of a variety of programs and services. Our largest program is the attendant services program, which provides assistance with activities of daily living to enable adults with physical disabilities to live in their own home.

Since 1981, the Ontario March of Dimes has provided 24-hour on-site attendant services in support service living units, known as SSLUs, and through outreach attendant services across the province. At present, Ontario March of Dimes operates 19 SSLU sites, 19 outreach attendant services programs and up to eight respite programs that service over 912 disabled persons annually with a combined budget of \$12.3 million. Our attendant services programs operate on a non-medical model that promotes consumer autonomy and self-directed care.

In the many public consultations on long-term care reform held over the last few years, the Ontario March of Dimes has encouraged its consumers, volunteers and staff members to express their ideas about this reform. This paper summarizes the position of the Ontario March of Dimes on long-term care.

Community Support Services: Ontario March of Dimes believes that the key principles of long-term care reform should be guaranteed access to essential long-term care services required by persons with disabilities and older people to live independently in the community. Long-term care reform must also retain choice for consumers in accessing services. Ontario March of Dimes strongly recommends that consumers maintain the option of accessing attendant services directly or through the multiservice agency. Competition in service provision will ensure that consumers benefit from increased quality through greater service accountability, and thus can truly act as consumers, choosing the service provider that best meets their needs.

In Hamilton-Wentworth and Halton, the Ontario March of Dimes, in conjunction with other similar service providers, such as Participation House, has facilitated meetings to discuss the multiservice agency model development. As well, in Niagara and Haldimand-Norfolk, a coalition of service providers and consumers has been brought together in each of these regions to educate the attendant services consumers regarding choice for access to attendant services as outlined in Bill 173. In addition, we have met with consumers individually and in groups. The consensus of all is that choice in accessing attendant services is essential. We agree that our outreach attendant services should be outside, but linked to a multiservice agency.

Consumers with disabilities have clearly stated that they do not wish to have a medically oriented service philosophy used to make important decisions in their lives. They believe that this philosophy will only perpetuate the notion of disability as illness and serve to promote dependency rather than independence. The non-medical, consumer-directed nature of attendant services should therefore be protected, while ensuring choice with respect to where and by whom the service is provided.

Service Provision and Assessment: Prior to the shift of funding from institutions to community-based services, Ontario March of Dimes urges that there be equitable local resources developed across Ontario to ensure that essential services such as homemaking, visiting nursing and attendant services are available in all parts of the province.

Ontario March of Dimes believes that assessment and service provision should be separate to avoid potential conflicts of interest. The multiservice agency staff should be trained to assess consumers in the broad context of their total wellbeing and independence and not just their medical needs. Consumers with disabilities should have input in establishing service and administrative standards for community support services to ensure that they meet their needs and not just those of seniors. As well, the boards of multiservice agencies should have a strong component of participation from consumers with disabilities.

Ontario March of Dimes supports the broad range of services provided by long-term care. However, the ministries of Health and Community and Social Services have made reference to the fact that personal support and professional services would be "generic" in nature. The concept of generic services should be carefully considered to avoid opting for the least expensive option rather than the best quality and most appropriate service.

Certain groups providing attendant services, such as the Ontario March of Dimes, Participation House and others, have developed specialized skills for servicing client groups while fostering integration. These skills, along with the options they represent, should not be sacrificed in pursuit of a generic service provider. When asked what they like about their attendant services, consumers invariably responded that services are tailored to their needs.

Respite Services: Additional support is required for family care givers. This support should include, but not be limited to, regular relief through easily accessed and flexible respite care services. A range of adult day programs provided without charge and financial compensation for family care givers is needed.

The availability of family care givers should not become a barrier to eligibility for any long-term care services.

Training and networking support to family care givers should also be developed in recognition of the enormous cost savings to government which this represents. The family care giver often provides services at large financial, emotional and psychosocial expense to himself or herself.

1120

Appeal process: There should be a single and expedient process in place for consumers and agencies to appeal decisions of the multiservice agencies. Services must continue while a decision is being appealed. The appeal committee must contain substantial representation of adult disabled groups.

Funding of long-term care:

(1) **Core services:** Ontario March of Dimes believes

that long-term care reform should proceed in the context of protecting Canada's universal health care system, restructuring services for greater effectiveness and efficiency and shifting to models of wellness and prevention.

We strongly recommend that funding also be provided for assistive devices and home modifications which allow individuals to continue living in their own homes.

Governments should ensure that consumers are not denied benefit coverage for items such as incontinence supplies by virtue of their leaving the home care nursing case load to receive services for an attendant services program.

(2) **Support services:** We are concerned that the possible transfer of funding for outreach attendant services programs to the multiservice agencies could jeopardize the smaller outreach programs. Many of these programs offer services which are unique and respond to consumer need in innovative ways. We believe the province should continue to directly fund the SSLUs and outreach attendant services programs.

Existing outreach attendant services programs operate with a fixed or capped budget, which limits the number of consumers it can serve. Most of these programs have waiting lists for services. In both Niagara and Haldimand-Norfolk, for instance, the waiting list, or number of requests for services not fulfilled, is equal to the number of consumers receiving attendant services; for example, 65 in Niagara and 18 in Haldimand-Norfolk.

As well, voluntarism as an integral part of attendant services programs requires a financial commitment on the part of the government. While volunteers should not replace staff, they can serve to enhance programs and contribute to extending independence and fostering integration.

(3) **Direct funding:** Ontario March of Dimes believes that direct funding, to consumers with disabilities, for attendant services should be a central option within the reformed long-term care system. The concept of direct funding would give consumers with disabilities confidence, experience in handling finances and managing people and help them to achieve greater independence by controlling decisions that affect their lives.

Supportive housing: As the long-term care reform process promotes community-based care in the home, the basic underlying assumption is that the recipient of support services has a home.

Many rural areas of Ontario, such as Haldimand-Norfolk and parts of Niagara and Halton, have a very limited accessible housing inventory. Haldimand-Norfolk has no supportive housing available. In recent supportive housing allocations, Haldimand-Norfolk was not included in the list of recipients. If equity in service provision is truly the goal of long-term care reform, then demographics such as rural versus urban populations must be factored into the equity formula.

Ontario March of Dimes believes that supportive housing should be encouraged in the widest possible range of housing types and locations. Our 13 years of experience in operating SSLUs demonstrates that the

SSLU is a successful model which merits expansion. The need for SSLUs is increasing in our local area. In Halton region, for example, we have processed 80 requests for attendant services and accessible housing for an available 22 units located in Oakville.

We therefore strongly recommend that the Ministry of Housing and municipalities collaborate to provide accessible, affordable housing units in the province and to encourage non-profit organizations to sponsor SSLU projects.

Conclusion: The Ontario March of Dimes encourages the Ontario government to enact Bill 173 in order to proceed with long-term care reform. However, local consumers have identified their desire to have services designed to meet their individual needs, that respect their right to risk and foster or enhance their independence. We are committed to working with the government to ensure that the reformed long-term care system respects the autonomy of persons with disabilities in choosing services which most appropriately meet their needs.

Summary: The Ontario March of Dimes has supported and continues to support the efforts of the government of Ontario to reform long-term care and community support services in this province. We feel these reforms must be founded on the principles and in the context of Canada's universal health care system and should include: guaranteed access to essential long-term care services; consumer choice in accessing services; a separation of assessment and service provision functions; an appropriate and speedy appeal process; adequate funding utilized in an efficient and equitable manner; expanded supportive housing initiatives.

Finally, we believe that long-term care reform must embrace and promote the notion that adults with physical disabilities and frail, elderly persons are not necessarily sick and in need of treatment, that when assistance with activities of daily living is all that is needed, access to the service should be direct, without delay and by the consumer's choice of service providers.

The Acting Chair: Thank you for your presentation. We have time for one short question.

Mrs O'Neill: Thank you very much for coming. Are you one of the pilot projects for the direct funding of the attendant care? Have you been lucky enough to be one of those?

Mr Overy: The direct funding pilot project is being handled through the Centre for Independent Living in Toronto. They are selecting and handling the candidates' requests. To my knowledge, there will be 80 to 100 individuals directly funded and no announcement has yet been made on who these people are.

REGIONAL MUNICIPALITY OF NIAGARA

The Acting Chair: The last presentation for this morning's session is the regional municipality of Niagara. Can you please come forward. Welcome. Please introduce yourselves to the committee, although you're well known.

Mr Roy Adams: Thank you, Madam Chair and members of the committee. We're pleased to be here.

Ms Bev Goodman: My name is Bev Goodman. I'm the manager of community programs in the senior

citizens' department for regional Niagara.

Mr Adams: My name is Roy Adams. I'm former mayor of the city of St Catharines, a regional councillor for the municipality of Niagara for 15 years now, a member of the Niagara District Health Council, completing six years this year, and involved in many other community activities.

Before I present our brief, I'd like to make just a few comments. One is to the effect that we in Niagara have been very fortunate over all the years of our existence to have at the helm of our senior citizens' homes and programs Mr Doug Rapelje, nationally and internationally known and recognized for his innovative and enthusiastic programs that he has provided, which have been copied and perhaps are trying to be copied in the program that we have in Bill 173. I'm very pleased to note that Mr Rapelje has recently been appointed to the National Advisory Council on Aging. I'm sure his expertise there will be most useful and beneficial.

We appreciate this opportunity to make, not comments alone regarding Bill 173, but our concerns.

The regional municipality of Niagara has a long-standing commitment to services for the elderly. Many of the principles of the redirection of long-term care are supported by the model we have developed since 1952.

For example, our department provides one point of access to the services of the department to community-based seniors—since January 1, 1994, permanent and short-stay admissions to our homes for the aged have been coordinated by Niagara Placement Coordination Service—six homes for the aged, providing 919 beds, including 11 short-stay, night care and intermittent care beds; a wide range of community-based options:

—Seven-day programs for physically frail, cognitively impaired and/or socially isolated seniors. Younger persons with special needs may also be accommodated. Over 200 persons are currently registered in this program. All programs can accommodate persons with Alzheimer disease or related dementia, and one program operates in a specially designed centre for the cognitively impaired. Transportation to the program is provided in specially equipped vehicles.

—Seventeen satellite homes (supportive housing program). These are private homes with an operator under contract to the region and, on average, three or four seniors. Many of these residents are developmentally handicapped or have a psychiatric history. This is an extremely cost-effective program. The per diem cost is about one third that of our homes for the aged.

—Home sharing. Clients are matched to share a home for companionship, financial security or service exchange. For example, a younger person may share the home of a frail elderly person, paying a reduced rent in exchange for doing the yard work, snow removal and heavy housekeeping.

—Alzheimer respite companion program, with 45 trained workers providing in-home relief for care givers of a person with dementia. Currently, 100 clients are registered and service can be provided seven days a week and overnight.

—Home help services. Some 7,740 seniors are registered with this program, which referred workers to do home maintenance, housekeeping, yard work and companion sitting.

—Friendly visiting. Some 93 frail and/or socially isolated seniors are visited regularly by our trained volunteers.

—Talk-a-bit (telephone reassurance). Trained volunteers contact frail and/or isolated seniors, both as security check and for socialization.

—Volunteer transportation. Volunteer drivers provide rides to elderly clients, primarily to medical appointments.

—Information and referral, for persons seeking the services of the department or other community-based services for the frail, elderly or their families.

—Public education. Our community programs staff organize and implement a number of education programs: Families Who Care—a six-week education and support program for family care givers is offered three times a year; Information Fair for Seniors and Their Families—agencies providing services to community-based seniors set up displays, provide staff and information. As well, seminars are held on such topics as the safe and effective use of medications, fire safety, home safety, back care etc.

1130

Concerns: We have carefully reviewed the proposed legislation and would like to raise a number of serious concerns. Our concerns relate to the integration of case management and service delivery functions; the standardized approach to services in communities; increased administrative costs; the bureaucratic nature of the system; consumer fees; the impact on volunteer services; impact on employees.

Integration of case management and service delivery: One of the "four basic principles of an expanded system," according to the minister's press release of June 6, 1994, is "integration of case management and service delivery." This integration is one of the fundamental changes in the government's approach to the community-based long-term care system.

The lengthy consultation process undertaken prior to the drafting of this legislation certainly indicated that clients and families had concerns about access to service and wanted to be able to contact one service to access a coordinated array of services to help them remain independently in their own homes. The primary issue thus was access and a coordinated approach to service. Clients also expressed concern about the lack of availability of certain services. In our community, for example, we had not been funded for the integrated homemaking program at the time of the consultations, and there were many concerns expressed about unmet needs for affordable homemaking and personal support services.

There has been no rationale provided to convince us that the integration of case management and service delivery will necessarily result in improvements to service delivery. While case management and service delivery may be integrated in the organizational model—in that

case managers and service providers will generally be employed by one organization—it is most likely that the two aspects will be done by different persons or units in the organization. In fact, the client would most likely deal with at least four parts of the organization: intake; assessment/case management; service delivery management/coordination; service delivery. Earlier visions of long-term care reform took the opposite approach, with a complete ban on the delivery of service directly by the new case management service.

In our opinion, each community should identify the solution that is most appropriate, taking into account its present system, geography, history etc to determine the extent to which case management and service delivery should be integrated.

Standardized approach to community systems: In a statement to the media, the Honourable Ruth Grier said: "I believe that change of this nature is best achieved with community involvement. This really is a partnership with the community. There isn't a cookie cutter at Queen's Park cranking out identical MSAs for communities to have in place at a set time. MSAs will be established in time frames that meet the needs of communities."

In fact, the legislation as proposed could be called a cookie-cutter approach. Programs to be provided are clearly listed under the categories: "community support services, homemaking services, personal support services, professional services."

The MSA will be prohibited from spending more than 20% of the amount budgeted for each of the program areas for the purchase of services and thus must provide at least 80% directly.

Many of the services, such as home care, which are major providers of service that would be included in the MSAs, have contracted for service from other agencies while retaining the responsibility for the overall coordination of the service plan to the client.

No evidence has been supplied that service would be enhanced if it were directly provided by the MSA rather than contracted for, and certainly no evidence has been provided that an 80-20 split in direct-indirect provision of service in all communities in the province of Ontario will enhance the service to clients and their families.

Community development of the new long-term care system should stress building on existing strengths and partnerships and on the long histories of many providers, volunteers and donors. These strengths should not be ignored.

In the Niagara region, for example, nursing and homemaking services are purchased from other agencies, most notably from the Victorian Order of Nurses and the Canadian Red Cross, two organizations with outstanding histories of non-profit service to the public.

Communities vary widely in their geography, urban-rural mix, proximity to major referral centres, proportion of elderly and physically disabled adults, current services and relationships. Communities should thus be able to plan the best way for the delivery of the mandated services to their clients, whether directly or indirectly, given a single point of access and coordination.

It may be questioned what role there is for the long-term care advisory committees to play in the development of the long-term care system in their communities with the inflexible approach outlined in Bill 173.

Increased administrative costs. It is claimed that the integration of case management and service delivery will reduce the overall costs of administration of the service system, and these savings can be redirected to service delivery. No evidence has been provided that these savings will actually occur, and examples can be provided of situations where costs would actually increase.

For example, the regional municipality of Niagara offers seven adult day programs, six of which are located in homes for the aged also operated by the region. Costs of the day programs including occupancy costs—rent, utilities, telephone, janitorial, maintenance etc.—are charged to the program. However, there is an availability of onsite management and shared responsibilities that would not be possible in the proposed model. For example, a registered nurse is assigned to the entire program to do client assessments, referrals, health teaching etc. However, if a client needs medications or first aid administered at the program, this is provided by the home's registered nursing staff at no charge to the program.

The MSA would need to increase the registered nursing staff significantly in order to provide the level of service that's currently being received by the clients, or formalize an agreement with the home to provide the irregular parts of the nursing service, and this could only be done at an increased cost.

There are many other examples in the service system where arrangements and relationships have been developed over time which are beneficial to clients and not a burden administratively.

The Long-Term Care Act seems to have developed on the assumption that the entire system is flawed. In fact, we believe there are serious problems that need to be addressed, but not with a standardized approach to be imposed on each community and requiring communities to discard the parts of their system which have worked so well.

Bureaucracy: The administrative work that would go into the provision of service will be cumbersome, expensive and unsettling to the client. For many services—for example, Meals on Wheels, friendly visiting, home help services—there is relatively little paperwork involved. While the new system will have the advantage of one point of access for service, it does mean that to access those services, the full bureaucracy of the MSA will be encountered.

The new system is intended to be consumer-focused, with many safeguards. Unfortunately, in their zeal to protect the consumer, the drafters of the legislation have gone overboard. For example, the approved agency is required to give a written notice with certain content to the consumer who is the subject of the plan; the person, if any, who is lawfully authorized to make personal care decisions on behalf of the consumer; the person, if any, designated by either the consumer or the lawfully authorized personal care decision-maker.

The notice must include a statement of the bill of rights and the obligation of the approved agency and its purchase of service agencies, if any, to respect and promote the rights of the consumer; procedures for consumers to make complaints or suggestions about the approved agency and its service providers, if any; a statement of the right of the person to have access to and an explanation of his or plan of service and personal record; a statement of the right of the person, the lawfully authorized personal care decision-maker and persons, if any, designated by these persons to review the service agreement between the minister and the approved agency; and any other matters that may be prescribed in regulations.

1140

We have attached a case example of the consumer seeking service from the MSA and an example of the resulting notice. In our opinion, the notice would do almost nothing to safeguard the rights of the consumer and would offend, confuse or intimidate many. In addition, the administrative cost of the notice provision would be excessive, with little or no positive outcome. It is vitally important to safeguard the rights of the consumer, but there are more effective ways to accomplish this: through agency policy, staff training, quality improvement programs, professional standards enforcement and public education.

Consumer fees: The bill states that the agency shall not require payment except in accordance with the regulations, which will apparently allow for a charge that incorporates common community living expenses. There will be a serious loss of revenue to existing agencies, for example, to those providing adult day programs, if this is implemented in the manner that is proposed in the draft guidelines for the adult day programs.

These guidelines suggest that charges would be allowed for transportation and food. This would not be based on the agency's costs, but the equivalent of the charge for community services; eg, public parallel transit and Meals on Wheels. These programs do not provide the same-day service that the day program provides. Public parallel transit programs provide only curb-to-curb service, while day program transportation may involve assisting the consumer with outer clothing, locking doors, assisting down the steps. Day programs also generally provide coffee and snacks in addition to the noon meal. These comparator programs, especially parallel public transit programs, are highly subsidized, and similar subsidy would be necessary to make up for the lost revenue from consumer fees.

Similarly, clients of the Alzheimer respite companion program pay approximately \$4 an hour towards the cost of the service. Eliminating the fee will result in the need for significantly more funding for the program or reduced services.

Revenue lost for these two programs in the Niagara region alone would likely be over \$200,000 a year. Eliminating fees will seriously reduce the chances of expanding much-needed services.

Impact on volunteer services: A fully implemented MSA will have a serious negative impact on many

volunteer services. While regional Niagara, a relatively large government organization, has had good success in recruiting and training volunteers as friendly visitors, talk-a-bit volunteers, volunteer office representatives, activity volunteers and volunteer drivers in its community programs, we are aware that many volunteers identify very strongly with a particular local community or with a particular client group or service.

Our current system allows for volunteers to choose the type of organization they wish to be affiliated with. These choices will be seriously reduced if virtually all volunteer work with the services for the frail, elderly and physically disabled adults must be channelled through the MSA. Volunteers play a vital role in the long-term care system and they need and deserve choices. Similarly, the fund-raising ability of the many volunteer boards will be reduced or eliminated.

Security of employment: In our region, there are currently many employers of persons providing community support, homemaking, personal support and professional services to elderly persons and adults with physical disabilities. These employees are currently staff of home care, placement coordination service, regional municipality of Niagara, 11 Meals on Wheels associations and a large number of voluntary agencies, such as the Alzheimer Society, the Victorian Order of Nurses and the Canadian Red Cross.

If an MSA is developed which integrates the intake, assessment case management, service management and service delivery currently provided by all these agencies, there are serious employee and labour relations challenges to be met. These problems are extremely challenging, and solving them will require significant resources and energy. If we are not assured that the new system will result in a better or more cost-effective service, then these resources and this energy could be better expended in the direct delivery of service to consumers.

Conclusion: Our review of Bill 173 has revealed very serious concerns. We believe that the passage of the bill in its present form will very negatively impact on the quality of services to our consumers, on the relationship of consumers and service providers and volunteers, on the ability of the individual communities to find the best solutions for their own communities and on many highly skilled and dedicated staff and volunteers.

Thank you very much, Madam Chair and members of the committee, for the opportunity.

The Acting Chair: Thank you very much for an excellent presentation. We do have a few minutes for questions. The first questioner is Mr Malkowski.

Mr Malkowski: Thank you for your presentation. There's one thing I'd like to talk about. You were talking about volunteer services. Perhaps there could be some kind of amendment to the legislation that would require an MSA to have a coordinator of volunteer services so that we can keep the volunteers and they can maintain the volunteers in their local areas and stay affiliated with the organizations they've been traditionally involved with. Would you have any feedback on that?

Ms Goodman: Certainly, we've found that volunteers

often have a very specific community or a very specific service in mind when they choose their volunteer work. The suggestion that it will require staffing in terms of volunteer coordination and management is correct. It's not a free service. Volunteers don't get paid but the recruitment, the training and so on can be expensive.

We recruit a lot of volunteers to work in our agency, but we also know that there are volunteers who will choose an agency that's much more focused and much more directed to their individual community rather than with our programs.

Mr Jim Wilson: Thank you very much for what is indeed a very excellent presentation to this committee. You've summarized a number of the concerns, and I think the accuracy of your brief is exceptional. The government tends to want to dismiss a number of these concerns and say that perhaps they're exaggerated. I don't think so and a number of other groups that have already appeared before the committee certainly back up your contentions.

I think the one big area—there are several, but the one I just want to focus on is your comment which I think was again right on with respect to the integration of case management and service delivery by the MSAs. When one starts to examine that, as you have, one could come to the conclusion and does come to the conclusion that what we're doing, I guess, is exchanging different agencies in the community now that are delivering services for a monopolistic multiservice agency with different departments. You make the case more clearly, I think, than anyone else has so far before the committee that people will still have to go through a number of different channels to receive service under an MSA, so is the exchange that's about to take place worth the pain?

Mr Adams: I would agree wholeheartedly. We believe that the system we've had in place has been effective, it's been appreciated and it's accomplished its task. If we're going to take and break that down and try to form new agencies to carry the torch, I think it's disastrous.

Mr Jim Wilson: Do I have time for a supplementary?

The Acting Chair: No, you don't unless the—there's time for one more question. Mrs Sullivan.

Mrs Sullivan: I think that one of the things you have raised goes back to the fundamental rationale for coming forward with this kind of a bill. You talk about the consultation process that led to long-term care reform and the discussions that occurred, and we hear from government members that many thousands of people were involved in discussions about the whole pace and changes that were required in long-term care.

I think in the beginning of your brief, on page 3, you indicate: "The primary issue...was access and a coordinated approach to service. Clients also expressed concern about the lack of availability of certain services." That is certainly our impression of what that consultation process provided, what the outcome was of that consultation process, and that the process and the people who were consulted never, ever contemplated that there would be a monopoly organization that would be set up to do

assessment, to determine who had access to what services and how.

I wonder if you'd like to comment further on that consultative process itself here and whether you concur that the people in this community did not ask for or want a monopoly on services and access.

Mr Adams: I had the responsibility and the pleasure of chairing the consultation committee on redirection of long-term care, and we travelled through the region. I've sort of said that everything we were being told and listening to and even proposed in the programs seemed to be going by the board, and, "This is the way it's going to be," and reinforcing our position: When programs were in place, why take them apart?

We realize there are communities that did not have the overall programs in place. There's where the addressing should be directed. Most importantly, get on with it and leave alone those who are capably running programs that are meeting the needs of and being given high commendations from the public, the citizens we serve, for the programs and the services we provide. I say leave us alone; let us get on with the job.

Mrs Sullivan: So you didn't hear a great outcry for a new organization.

Mr Adams: Absolutely not, ma'am.

The Acting Chair: Thank you very much for an excellent presentation. I know the committee appreciated hearing from you.

The committee stands adjourned. We will be taking a five-minute break and then meet for a working lunch session beginning at 12 noon. We will reconvene probably at 1:30. Thank you all.

The committee recessed from 1152 to 1212.

MINISTRY OF HEALTH

The Acting Chair: We're going to begin the working session now and ignore the munchies. If we're ready to go, there's a slide presentation, I believe. It would be helpful, Geoff, if you could introduce who's going to do what and just bring the committee up to date.

Mr Quirt: Certainly. Thank you, Madam Chair, committee members. We're prepared today to do three presentations for you, as requested. One presentation is a technical presentation of the bill itself, the various sections and what it's intended to achieve. A second, shorter presentation you've requested is a brief update on the program design activities under way in which a number of consumer and provider stakeholders are involved, and a third presentation is a presentation on the work to date, our current thinking on eligibility criteria for services from the new MSA.

I want to make it clear that we're completely at your disposal, so that if you feel you wish to continue the discussion on the legislation, for example, our staff will come back whenever you'd like to continue with those other two presentations. So we wouldn't want you to feel constrained. We will adjust our schedules to yours to make sure you have as much time as you feel is necessary.

I'd like to introduce Gail Czucar, who you all know,

who will be doing the legal overview, and also Jean McCartney, who is at the presenters' table, who is our manager of program design in the long-term care policy branch of the long-term care division.

With that, we'll ask Gail to take you through each section of the bill. There are some materials we'll be handing out that you may wish to follow as she's going through her presentation.

Ms Gail Czucar: Thanks, Geoff. There is a package of materials, overheads, that was handed around. I think it says "Highlights" on the top. I was going to use these to make my presentation, as I've been doing briefings for other groups and so on, but given that the committee was pretty clear yesterday about what it wanted, which was to go through the act section by section, that's what I'm going to do. I'm going to try to do it fairly quickly and respond to some of the issues that have arisen so far but not take up the whole hour. So this may be a bit of a challenge.

I'll just start with section 1, the purposes of the act. We've heard some people talk about these already. This, as you know, is a general statement section that sort of provides a context and background for how the act is to be interpreted and used.

Part II, the definitions: I'll just draw your attention to a couple that we've already dealt with; the definition of "agency," which is pretty fundamental to the act because a multiservice agency is an approved agency that has been designated by the minister as an MSA. So the first thing to do to become a multiservice agency is be an agency, and who can be an agency is a non-profit corporation under the Corporations Act or a non-profit cooperative corporation, a municipality, a board of health or a council of a band. The other definition that we've talked about fairly often is the "care giver support services," which includes respite care and other sorts of things.

I might just say that some of the services that are listed in this section farther on in the categories are defined here and others are not, and the reason for that is that some were felt to be fairly clear in terms of ordinary meaning. Of course the principle of statutory interpretation is that if a term is not defined in the act, then it has its ordinary meaning and you can turn to the dictionary and other sources to discover what it means. It's only where the act seeks to have a particular meaning to a term that might have a different ordinary meaning that we would define it in the act. "Care giver support services" had to be defined in order to give some idea of what kinds of things would be encompassed there, and similarly for some of the others that are in the definition section.

I'm not sure that there are other definitions. I guess the other one that has come up is the "service provider." "Service provider" means, and there are a number of things listed there, "the minister, if the minister is providing a...service...an approved agency...a person who provides a community service"—that is, who is funded by the ministry to provide a community service, and "community service" is the generic term for all of the services that are listed in the four categories in the next subsection—and "a person who provides a...service" that is

"purchased by an approved agency." As we mentioned yesterday, "person" here includes corporations, so it can include any agency or commercial provider from whom an approved agency purchases a service.

As we'll see, there are different obligations and rules which apply to service providers and to approved agencies. Generally speaking, approved agencies have more obligations than do service providers.

Further on in the definitions section, we have the four categories of services. I don't know that I need to say too much about those: community support services, home-making, personal support and professional services. There may be some questions about those later.

Part III is "Bill of Rights." This bill of rights was put here in order to have some consistency with the facility sector, because there is a bill of rights, as we know, included in all of the facility statutes. This bill of rights is based on that one with the ones removed that pertain pretty much to people living in a residence. Many of the rights in the bill of rights in the facility statutes have to do with the residential nature of those programs, so these were adapted to be suitable to community services. They're general statements of rights: to be treated with dignity and respect, free from abuse, having services that promote autonomy and so on and so forth.

Again, this is intended as a statement of expectations for both consumers and providers, to make it clear what we expect, and as a backdrop, again, for interpretation of the act; that's what's said in subsection 3(2).

The enforcement mechanism in subsection 3(3) is a deemed contract. This is a case where the obligation is between every service provider, that is, anyone, whether on a contract basis or independently, who provides a service under this act must respect these rights and is deemed to have a contract with the consumer to that effect.

Part IV, "Directors and Program Supervisors": The reason that this is here—I think this has been misinterpreted somewhat—is to allow for the appointment of officials—these would ordinarily, in almost all cases, be ministry employees; they would not be people from outside—to perform the functions of someone called a director or a program supervisor.

1220

I don't believe that we've ascribed any functions in the act to the director. Under other acts which govern programs that will come under this act, particularly existing statutes that govern the services formerly administered by Comsoc, directors have functions defined in the acts, and we may very well need to define particular functions for a ministry official who would be called a director in the regulations. If we chose to have complaint process obligations or something like that, we might require the director to do certain things. In the facility statutes, for example, the director has the function of issuing licences and that kind of stuff. So that's the reason this is here. These do not refer to directors of multiservice agencies or any service providers outside the structure of government.

Similarly, the appointment of program supervisors:

There are of course program supervisors within the structure of the ministry, and they work in the area offices for the area managers. Area managers, by the way, are designated as directors for the purpose of other kinds of administrative delegation within the ministry, and they could very well be the ones who would be designated as directors here, depending on what functions they would take on.

Program supervisors do have a function within the act, and that's dealt with in the section on inspections. So program supervisors have to be appointed by the minister to have the authority to carry out those kinds of things that are set out in that section further on in the act, and this is what circumscribes them.

This also allows the minister to appoint, in unusual cases, someone outside the act as a program supervisor to do something like carry out an independent investigation of a complaint or something like that. That's why it's not restricted to employees of the ministry but allows for the appointment of someone outside the act where that's necessary. That's why subsection 4(3) talks about putting conditions or limitations on an appointment.

The immunity section in section 5 is a fairly standard one in legislation, which says that the director or program supervisor is immune from liability personally for acts done in good faith and so on and so forth, but the crown is liable because it's accountable for the actions of this official who has been appointed by the crown.

Part V, "Funding and Approvals": This is a general funding statute; that is, it sets out that the minister can make agreements with people to provide services under the act, to make payments, provide financial assistance. It's not dependent upon detailed regulations as the facility statutes are, which state that payments can only be made in accordance with the regulations. This is a much more general funding authority and also allows for capital funding and grants and contributions where there are, in some cases, shared funding arrangements between the ministry and other organizations or municipalities. So it's a quite broad funding provision.

The approval section in section 7 has to do with approved agencies. "The minister may approve an agency to provide a community service if the minister is satisfied that...the agency...will be financially capable of providing the service; and"—and it recognizes that that's with financial assistance from the ministry—"is or will be operated with competence, honesty, integrity and concern for the health, safety and wellbeing of the persons receiving the service."

The reason that these conditions for approval are important is because later when the minister can revoke an approval or suspend an approval or take over an agency, of course it refers back to these kinds of conditions for approval and also just provides an accountability mechanism for the ministry.

There is the possibility of retroactive approvals for cases where an agency may be up and running, needing to get up and running, and able to provide a service or take on certain functions before the official approval has been processed and so on.

It would be anticipated that existing agencies that are performing functions outlined in the community services would be approved as agencies when the act is proclaimed in order to carry on with the existing system until such time as multiservice agencies are designated in each area in order to be able to take on those services and those functions.

The other purpose of having approved agencies in the act is that some of those agencies will continue to deliver services separately from the MSA and be funded to do that. One example is the attendant care programs, as we've discussed. They can continue to be funded by the ministry separately if that's the decision of the group of people who are receiving services from those agencies in that community.

The "Approval of premises" is simply that the minister can approve particular premises and revoke an approval. Again, it's an accountability provision.

Terms and conditions on approvals, terms and conditions on financial assistance and security for payments, these are again accountability provisions between the ministry and the agency.

Part VI, "Multiservice Agencies": These really set out how multiservice agencies are designated and what the expectations are. The minister has discretion with respect to designating an approved agency as a multiservice agency for a specific geographic area, but there is provision for overlap. That's in subsection 11(4), that the minister can designate more than one MSA for the same geographic area. This was specifically to allow for the possibility, for example, of a francophone MSA that might cover the same area as other MSAs or ethnic- or cultural-specific MSAs.

In deciding whether to designate an approved agency as an MSA, the minister is obligated to consider whether the board reflects the diversity of the persons to be served in terms of gender, age, disability and so on. This is the consumer participation provision that sets out the specific factors that the minister has to consider and also whether it includes persons experienced in health and social services.

I might say that the drafting is based on the principle that we need flexibility; that the act is to set out a framework and some guidelines but also be flexible enough to take into account the recommendations of the district health councils and the wishes of local communities. We've attempted to achieve a balance between giving people enough guidance that they know what they're supposed to do and not being too prescriptive, being as flexible as possible.

So that is one of the reasons that there's very little in the way of criteria for designation. It leaves it to the discretion of the minister so that it can accommodate any model that the community comes forward with, with the bottom line that the board must include consumer participation, and that's why this is here.

Subsection 11(3) also expresses a preference for independent, non-profit agencies as opposed to boards of health or municipalities while still allowing the minister to consider boards of health or municipalities in instances

where there may not be any other choice. That may be the only alternative in a community, and so the minister can appoint a municipality or a board of health or designate them only if she's considered the suitability of all other approved agencies in that area. Terms and conditions can be imposed on a designation or amended.

In section 12, we have the statement of the mandatory services that are to be provided by an MSA. They're in the four categories. We've discussed that. They exclude the paragraph that talks about supplies and equipment and related services. The MSA must provide those, and we can prescribe additional ones.

Again, these powers to prescribe, both in the definition sections and in this one are intended to allow flexibility. They're intended to recognize that legislation doesn't come up very often and that if the system is going to develop over 15 or 20 years, there may be services we don't anticipate at this point that we can put in the act but may need to be added as obligatory services later on.

We can do that by regulation, and that's why that's there. These do not have to be prescribed in order for the act to be proclaimed. As far as I know, there's no intention to prescribe any additional services in the definition section or in this section at this time. If there were, we would include them here, but again it's intended to provide flexibility for the future.

1230

Optional services can also be provided by MSAs under subsection 12(2) if the minister authorizes these. The intention here was simply that with a plan that's brought forward for an MSA where an MSA may want to have services not mentioned here that are appropriate to the local community, the minister would want to authorize that since the minister obviously is going to be approached for funding on those. Also, where the MSA might be part of a larger organization, such as a comprehensive health organization or other kind of setup, the minister would want to authorize that so as to ensure compatibility and that sort of thing.

In section 13 we have the limit on purchase of service, which is 20% of the amount in each category of the budget. There are then certain exclusions from that which are referred to in subsection 13(3). The equipment one—which we've discussed already in the committee—short-term absences, backfill, essentially, and that sort of thing, would not be included in the 20% purchase, and where the service provider is another MSA or an individual—we've discussed that as well—that would not count in the 20%.

So the 20% was intended to allow for the need to purchase particular kinds of highly specialized services or services provided by hospitals or other service providers that wouldn't be needed on a regular basis. Also, the purchases from individuals and that sort of thing that are excluded was to allow for the purchase of service from someone, for example, in a rural area where someone may live in a community quite far from the MSA and it wouldn't be cost-effective to have someone in the MSA going out to that person. You could hire someone in the local community, and that wouldn't count towards the 20%.

In section 14, the information and referral functions are basic functions of the MSA, and they're required to provide those.

Section 15, "Exemption": This is what's been referred to I think a lot as the transitions section. This is to allow, again, flexibility, where the minister, in designating the MSA, can exempt it from having to provide some or all of the services. This can be service by service. This exemption can be tailored to the specific plan that's presented to exempt the MSA from the obligation to provide one of the homemaking services or one of the attendant care services or a whole category or all of them, for that matter, and also from the 20% limit.

Again, this can be tailored. So if there's a group of agencies that provide community support services that are not yet part of the MSA, then they can be exempted from the 20% purchase requirement for up to four years. Again, the four years is not mandatory; it could be for a period less than that. But the maximum would be four years from the date of designation.

I just want to be clear that what this says is that the MSA is designated at this point; it's just exempt from some of the requirements that it must meet. It is an MSA. It's not an interim MSA or a transitional MSA or a pre-MSA; it is an MSA. It's just exempt from some of those requirements until the end of the four years.

Part VII sets out the rules governing approved agencies. There are a number of them here. I don't know, I guess I'll just go through them. The transfer-of-assets provision is, again, a fairly standard administrative one that simply allows for accountability for the use of provincial funds to purchase capital assets and so on; that they can't be transferred to another organization except in accordance with the regulations. That might be that some kind of written approval is required or something like that.

In section 17, the employee not being a director of the agency, we've dealt with this. This again is a principle of accountability that employees not be part of the board of directors. It's seen as a conflict-of-interest prevention.

The bylaw requirement in section 18 is that the agency has to pass bylaws that contain provisions prescribed in the regulations for the class of agencies to which it belongs.

This is a provision that allows us to make regulations, if we wish, setting out the kinds of membership provisions we would like to see MSAs or approved agencies have, the kinds of election procedures they might have to ensure consumer participation or participation of a broad range of providers and that sort of thing. It's not intended, again, that this be used immediately. It's there for the future, if necessary.

The filing requirement in section 19, that approved agencies file a copy of their bylaws with the ministry, that these contain the letters patent and the actual bylaws and amendments and a certificate from a solicitor that those bylaws comply with the act and the regulations and so on, is intended to be a check on the governance side of things. That is, if there are any regulations requiring the agency to have particular bylaws, we want to have a

solicitor's certificate that they do that, and that would ordinarily be the solicitor that's helped the agency with its incorporation and so on.

Again, it's not intended that these be used, but these are the mechanism for ensuring that MSAs are having consumer participation and so on. This is because you need a follow-up to the provision that the minister can designate an MSA and has to take into account certain things. But the fact is that the organization can have a meeting six months later or a year later and change the composition of its board entirely, because it is an independently incorporated corporation and its bylaws set out the rules which govern it; we don't control that. If they chose to change the composition of their board to something that was very different from what the minister had initially approved, this would be our way of finding that out and our way of having some input into that to ensure that it would change.

The only other option to have a check on that would be to allow the minister to revoke the approval that she had given in the first place, or the designation, based on the fact that the board no longer met the requirements, but that's a pretty drastic thing to do, as I'll talk about in the takeover sections.

We've talked about the plan-of-service requirement in section 20 a fair amount. This was our description of the case management function and the basic requirement about assessment, determination of eligibility and the development of a plan of service that says how much service of each kind of service the person is going to get, an ongoing requirement for a review.

This section again, clause 20(2)(a), reviewing "the person's requirements when appropriate, depending on the person's condition and circumstances," I think we've heard from some presenters that they want this to be more onerous on the agency, that it be required at particular intervals or something. We discussed all that and felt that because of the wide range of services and demands that there might be, we wouldn't want to impose an onerous requirement like that on every agency, and people don't want to have assessments if their condition hasn't changed in five years. So, again, this is meant to be responsive and flexible.

"Participation in plan of service": This is the requirement, as we saw in the facility statutes, where the person and anyone that they choose can participate in developing and revising the plan.

Subsection 20(4) again allows for criteria to be prescribed, procedures to be prescribed for assessing and standards. This is a section that will pretty much have to be used before the act can be proclaimed, because the eligibility criteria which are currently in effect for the home care program under the Health Insurance Act, for the homemakers and nurses services program, integrated homemakers and so on under the Homemakers and Nurses Services Act and other statutes or agreements will have to come into effect under this act when it's proclaimed in order to maintain the existing system until, again, MSAs are proclaimed.

This, of course, is a core feature of the act: having a standard set of eligibility criteria and assessment pro-

cedures and so on across the province. This is to allow those to be put in place and also again to be flexible enough to accommodate all the different kinds of programs and the range of programs that are anticipated to come under the act.

1240

Section 21 then requires the agency to deliver the services they put in the plan of service, but allows for waiting lists where the service is not immediately available.

Section 22 is a consent requirement. People can't be assessed or provided with services without consent. That's fairly standard.

Section 23, "Notice," that we just heard one of the presenters talk about, again is comparable to what we had in the facility statutes. This is a consumer accountability mechanism, and a very important one, to give people information about what their rights are under the act, what agreements there may be between the agency and the ministry so that they know what services they are expected to provide and are funded by the government to provide, procedures for making complaints and procedures for getting access to the plan of care and an explanation of the plan of care. I think that point came up in one of the presentations, actually. Also, requests for access to their records.

There's a "Quality management" section, in section 24, requiring approved agencies to ensure that a quality management system is developed.

We've talked about sections 25 and 26. These are the charging sections. Section 25 says that if a professional or personal support service is required by a person's plan of service, the approved agency cannot request payment for that or accept payment for that. If it's a homemaking or community support service in the plan, the only charge that can be made for that service is one that's set out in the regulations. The regulations, if there are any under this section, could set out a range of fees that could be charged for kinds of services. So for meal services or transportation services, we could set out a range for across the province, a minimum and maximum, or a formula or some other means of determining it. Again, it's quite broad how that could be used.

In section 26 we're moving now into the rules that govern service providers. The ones I've just talked about are requirements of approved agencies, ie, MSAs, agencies which will be approved in the interim to continue carrying out the existing programs and others that may be continued as approved agencies separate from the MSA.

The service providers, now these rules would apply to anyone, including commercial providers or others, from whom services might be purchased. They cannot accept payments for services that are community services purchased by an approved agency. I guess that's fairly clear. Again, these are consumer protections so that consumers know what they can be charged for and what they can't be charged for, as well as restrictions on service providers.

Subsection 26(2) allows the service provider to collect

a fee, if there is one allowed under section 25, from the person. This is to recognize the reality that where a person gets a meal or a transportation service and there's a minimal charge for that, the service provider can collect that money from the person and deliver it back to the approved agency. You don't have to have a bill collecting system in place, which would be kind of ridiculous for the approved agency to have to collect it separately. So that's what subsection 26(2) is about.

Section 27 is a reporting requirement, and again it's a very general one. If the minister wants to require particular kinds of reporting from service providers, then there's a requirement to do that. Again, there's no intention at this time that I know of to impose that.

Section 28 is a posting requirement to the service provider to post in the business premises a copy of the bill of rights and any agreement between the service provider and the ministry where the service provider is receiving funds to provide the service directly and not purchased by an approved agency.

Section 29 is the access to personal records section. This says essentially that a person who's receiving a service from any service provider has a prima facie right of access to their record, and that includes any information that the service provider may have collected from others in the process of assessment or whatever. Because it's a prima facie right, the service provider has the onus to apply to a review board if they propose to not give the person access. So if they want to withhold part of the record for some reason, they have to go to a review board.

This is comparable to provisions under the Mental Health Act with respect to information in psychiatric facilities, and the same review board is used, that is, the review board under the Mental Health Act, until such time as the consent act is proclaimed and we have the Consent and Capacity Review Board set up. The only grounds on which the review board can make an order allowing the service provider to withhold part of the record from the person is that there might be serious physical or serious emotional harm to the person or another person. In that case, the board can authorize it.

Section 30 allows the person, once they've had access to their record, to request a correction. If there's something in the record they feel is inaccurate, they can request the service provider to make a correction or to include a statement and to let anyone know who has had access to that record in the past year that there has been a statement of disagreement and what it is.

Section 31 is a general compliance section, which simply requires service providers to comply with the regulations and the act. That's for the purpose of the offence provision later on.

Part IX sets out appeals. These provisions are virtually identical to those that were in Bill 101 with respect to facility appeals on eligibility, with the exception that the scope is broader. A person can apply to the board for a review of a decision by an agency that they're not eligible, excluding a particular service from their plan of service—so they may be determined eligible for nursing services but not homemaking; they can appeal the

homemaking decision—respecting the amount of a service or respecting termination of a service. As I say, these are pretty much the same.

I guess I won't address the issue of alternative appeal mechanisms. There are other kinds of things, of course, that can be done and should be done by way of appeals and reviews of decisions prior to getting to this stage, but this is the final independent tribunal that's available. Again, this is already in place for home care. Under the Health Insurance Act, the Health Services Appeal Board would hear appeals from anyone who wanted to contest their eligibility for home care. So this is not new at all.

Part X, "Revocation and takeover powers": These powers are currently in the Ministry of Community and Social Services Act for those programs that have been funded and provided by Comsoc. In the transfer to the Ministry of Health, they would no longer apply because of the way they're written in that act, so they've been put in this act to apply to agencies, and they apply to multi-service agencies as well. The minister can revoke or suspend an approval of the agency or the premises on the grounds specified here, that they've contravened a term or condition imposed on the approval, they've contravened the act or the regulations, breached a provision of an agreement or they no longer are able to meet the initial conditions of approval that I talked about, not being able to operate financially or not operating with competence and integrity and so on.

The takeover provisions are based on many of the same grounds, that is, if the minister believes on reasonable grounds that those things are happening, she can also take over the agency as opposed to simply removing their approval. It can also be done on an emergency basis, where there is a threat to the health or safety of a person.

1250

Section 45 sets out the procedure, the due process of it; that there has to be a notice, there has to be a hearing and that kind of thing. Where a takeover is done on an emergency basis, the hearing would be held afterwards. I don't know if you want me to get into the specifics of those. Time is kind of marching on here.

Some of the general provisions in part XI have to do with the minister being able to delegate her power. Section 51 is the subrogation provision. If anyone would like me to explain subrogation in detail, I'd be happy to attempt to do that. This is, again, a question of the transfer from the Ministry of Community and Social Services to Health.

Briefly, subrogation is the right of the minister to recover costs where a wrongdoer has been the cause of a person's injury and the ministry is funding services that are provided to this person. There may be an insurer or some other person, usually an insurer, that is obligated to cover the costs of those services. The ministry can recover them. Those subrogation rights were contained in the Ministry of Community and Social Services Act. Our subrogation rights are in our Health Insurance Act, so in order to just maintain the status quo, we had to put them in to cover the community services under long-term care. These procedures that are set out here are similar to the ones under the Health Insurance Act, so that anyone who

is subject to subrogation provisions will have to follow the same procedures under this act or the Health Insurance Act.

Section 51 is the exemption under the Public Vehicles Act that will allow community service providers and facilities to have transportation services for people who aren't able to use the regular system or who need some additional assistance without having to obtain a public vehicles licence, but it still maintains some of the provisions of the Public Vehicles Act that apply to safety requirements and so on.

Section 52 is the inspection section. As I mentioned before, program supervisors have the powers to do inspections, and these powers are pretty much comparable to those which we discussed under Bill 101. They cannot enter a dwelling except with the consent of the person. If they need to carry out an inspection and the person doesn't give their consent or there's some other problem, they'd have to go under the Provincial Offences Act to get a warrant.

There are offences listed in section 54. Not every section of the act contravention constitutes an offence, but they're listed there in clause 54(1)(b). They include things like the obligations on service providers that I mentioned to respect the act and the regulations. Some of the provisions under subrogation and the inspection section constitute offences.

The regulation-making power in section 56, which has been mentioned by a number of presenters, includes a number of different powers. I certainly won't go through all of them. I will draw to your attention paragraph 56(1)11, which talks about requiring MSAs "to develop and implement a plan for recruiting and using the services of volunteers." The reason that's there and is written the way it is is because, again, we didn't want to impose on every agency the obligation to have a program or a coordinator or something like that. Again, it's to remain as flexible as possible. This would allow us to impose this requirement on MSAs at such time as it's realistic to do that in their evolution.

The other regulation-making powers, as I say, most of these would not need to be used right off the bat in order to proclaim the act. The one that would be necessary would be the eligibility criteria, in order to be able to carry on the existing system in certain areas and for people to know what their eligibility criteria are, because we would have to repeal the other provisions that are currently in place. Other than that, most of these are for future use in terms of the system changing and evolving and needing to have rules imposed in various ways.

We have a substitute decision-making provision that's transitional, and that ends the Long-Term Care Act. The amendments to the Charitable Institutions Act, Homes for the Aged and Rest Homes Act and Nursing Homes Act, the facility statutes have to do with reinstituting the takeover powers and revocations of approvals for charitable homes and homes for the aged, which were formerly in the Comsoc act, and a regulation-making power for access to records. We didn't put access to records sections in those statutes. That may be something we want to look at.

The amendment to the Health Protection and Promotion Act simply removes, as I mentioned before, the obligation of boards of health to provide home care. That was a mechanism that would ensure that home care services be available in every community in the province. That obligation will now fall on multiservice agencies. So we no longer want it to fall on boards of health.

The Homemakers and Nurses Services Act is being amended to remove the integrated homemaker program, essentially, because that will now be funded under this act. But the existing homemakers and nurses services programs in municipalities and band councils would continue to be governed by homemakers and nurses services.

The only other one I think I want to mention is the Ministry of Health Act amendment, which has to do with district health councils, in section 62. For the first time, district health councils are mentioned specifically in the act. They have been appointed previously under section 5, I believe it is, of the ministry act or section 9 as advisory committees to the minister. This provision specifically sets out district health councils and the ability of the minister or cabinet to establish the council and specify the area for which they're authorized to perform functions.

In making the appointments, cabinet or the minister are to take into account the importance of ensuring that the membership reflects the diversity of the population. Again, this is a representation requirement to ensure that district health councils are representative of their communities.

The functions are listed here: advising the minister on health needs and other health matters; making recommendations on allocation of resources; making plans for development of a system and any other duties that the minister might assign. These are the existing functions of district health councils. They aren't expanded here; they're just articulated in the act for the first time.

Subsection 62(5) allows for the development of aboriginal health authorities in the future where aboriginal communities want to set up their own planning and delivery and management organizations, in which case the district health council would not perform its advisory functions with respect to those services or may cooperate with the aboriginal organization.

Finally, a provider of health services can be required by the minister to provide plans and information to the minister and district health councils. This is to assist district health councils in carrying out their functions, obviously, where they need information from providers in order to do that.

There's a regulation-making power. Some people have mentioned that the ministry should require district health councils to have particular people on their long-term care subcommittees or that sort of thing. There is a regulation-making power that would allow us to make regulations to do that and would also allow us to make regulations regarding the recruitment process in DHCs, because it's recognized that this is fundamental to the representativeness requirement that I previously mentioned.

I think that's all I will say about the act at this point.

Mr Quirt: Would you like to have some questions on the legislation?

Mr Monte Kwinter (Wilson Heights): It seems to me there's a contradiction in one of the provisions. If you look under part X, "Revocation and Takeover Powers," it says, in clause 41(a), "The minister may revoke or suspend an approval of an agency given under subsection 7(1) if,

"(a) the agency is located in a geographic area for which the minister has designated another approved agency as a multiservice agency."

The implication of that is that the minister could revoke your approval because there's another one or you have more than one. Yet, if you back to part V, "Funding and Approvals"—

1300

Ms Czukar: Do you mean the provision which says that there can be more than one MSA?

Mr Kwinter: Yes.

Ms Czukar: It's not contradictory. What this is meant to say, in clause 41(a), is that if the minister has designated an MSA, then those approvals that are out there for certain agencies will be taken back so that you don't have a duplication. That's what it's meant to deal with, a situation where you've had an approved agency delivering some of those services. They're now going to be part of the MSA. You don't want them out there as an approved agency because they're no longer subject to the rules and performing the functions under this act with respect to that. They're now part of the MSA.

This is not meant as a punitive kind of a provision. This is simply a case of making it consistent so that if you have an MSA that's an approved agency doing those things then you don't have another agency approved to do those things as well. It could eliminate a potential conflict or inconsistency.

Mr Quirt: I can see how it would be confusing, however, given that it might imply that designation of two MSAs for one area was problematic when you see it as a reason for revocation. So I think it was a good clarification to make.

Mr Kwinter: My concern is that someone gets designated as an MSA and then another group comes along and wants designation and they refer to this, saying, "Well, this implies that there can only be one." Yet on the other hand, in a previous section, it provides for the minister to provide for more than one MSA in one geographic district. That is where I feel there could be some—there's no confusion in your mind, I understand that, but this has got to stand alone, and when someone reads it, it could be interpreted that the implication is that there can only be one, if you read this section, whereas in the previous section there is a provision for the minister to provide for more than one.

Ms Czukar: Yes.

Mr Jim Wilson: Well, let's start at the end then. When this act comes into effect, given that I have no doubt it will in some form, will district health councils

have to be reconstituted or are they grandfathered, the ones that are currently up and running?

Ms Czukar: My interpretation would be that their existing OICs would be in effect and would continue.

Mr Jim Wilson: What's an OIC?

Ms Czukar: Our order-in-council appointing the members of the district health councils. So it's not intended to do away with the existing ones and start over.

Mr Jim Wilson: But what if the existing ones don't have the mix of membership that's required? Say they're not reflecting their communities now.

Ms Czukar: Well, the provision is that in selecting persons to be appointed the minister shall consider the importance of ensuring these things, so it really refers to appointments as they come up. It doesn't say every district health council must be this way on day one; it says as the appointments are made, these are factors that have to be considered.

Mr Jim Wilson: Okay, and can I just ask what's different, since I don't have a copy of the Ministry of Health Act in front of me, with respect to—it says, "Clause 12(d) of the act is repealed and the following substituted." It's talking about recruitment and composition. What are you repealing?

Ms Czukar: That's a good question. I'll have to look that up.

Mr Jim Wilson: Because I—

The Acting Chair: I'd like to move along because we have one more presentation, the slide presentation that I mentioned earlier. If we have time at the end of that, then we can ask all of our questions; if we don't, we're going to cut into our presentation and we'll have to cut off, because I think the deputants should be on their schedule. Mrs O'Neill, one short question.

Mrs O'Neill: I get one? Okay. I'll go for a follow-up to Mr Kwinter's then. The geographic areas, when and how will that be determined? I know that we're talking different numbers in Metro Toronto. We had the presentation from East York. They think they could be one, and yet their population is 100,000. I've heard 225,000. Where are we going with geographic areas?

Ms Czukar: These are not going to be prescribed by the ministry; they will be based on the plans that come forward from the district health councils. So in making the designation and designating X as the multiservice agency, the minister will say, "X is designated as a multiservice agency for this area," and it will set it out in the designation. So it's not like the ministry is taking a map and dividing it up and saying, "This is going to be the one for this area, and this one for this area." It depends on what comes forward from the district health councils and what the ministry agrees to approve. So they will be individual.

Mrs O'Neill: It's got no relationship to population?

Ms Czukar: Not so far as I know.

Mr Quirt: At this point, there's no particular policy established that would require an MSA to serve a minimum number of people, and as has been pointed out, we've really asked the district health councils to tell us

how many they think they need in their area and what boundaries they should cover. Theoretically, I suppose, the DHC might recommend that 10 people in this one particular township need an MSA, and the minister would at that point have to say: "I'm sorry, I can't take your advice. I'm going to do something a little different." But we don't expect that to be the case.

Mr Jim Wilson: Could I just very quickly run down four concerns, and maybe counsel would want to get back to me?

I still need a clarification of how attendant care fits in. You talked about how it would still continue to be funded separately, but the bottom line is that it would really help a lot of groups if we could somehow get the words into the community service section somewhere.

Bill of rights: As far as I read it, it applies to service providers, but how is it binding on the actual approved agencies or MSAs? I'm a little unclear about the relationship there.

Ms Czukar: The definition of "service provider" includes them. "Service provider" is the most inclusive definition, so it includes MSAs, approved agencies and anybody else who delivers a service.

Mr Jim Wilson: So in cases where MSAs are actually providing services, which will be 80% of the time I guess, they're bound there, and then anyone contracted out?

Ms Czukar: That's right.

Mr Jim Wilson: Okay. Condition of approval: Clause 7(1)(b), with respect to approval, is that a normal wording? It seems to me it's a very broad condition when you're talking about someone having to judge competency, honesty, integrity. I mean, it can go both ways. Approval might be okay in doing that, but then if the minister had a bad day and wanted to revoke one of these things, that gives you pretty sweeping reasons, and loosey-goosey reasons, to withdraw approval of an MSA. It doesn't seem to me to actually fit in with the more legalistic leanings of the bill. I mean, this is rather layman's language, when you're talking about competency and honesty. So, parliamentary assistant, I'll ask for a comment with respect to that. It just doesn't seem to fit with the rest of the bill.

On subsection 11(3), I just want a clarification again with respect to why there is a built-in bias against municipalities and boards of health, and a clarification on subsection 15(2) with the exemption of the 20% rule. My understanding of this is that after four years there is no more flexibility. Is that true?

Ms Czukar: That's correct.

Mr Jim Wilson: So the flexibility that you talk about is only good for up to four years, and then it's a strict 80-20 rule with the exemptions that are in other parts of the bill.

Ms Czukar: That's right. With respect to that one, that's right.

Mrs O'Neill: Madam Chair, if I may just put one thing more in the same manner? Both the news clippings and some of the presenters and the minister herself talked about—really, "delisting" is the colloquial term that goes

on through this bill, that there will be certain services that will no longer be covered under, I presume, the health insurance plan of the province. Could you point out to us the exact sections where the changes are going to take place under that with that particular intent?

Ms Czukar: The home care program, which is in the school health support services programs, are sections of regulation 552 under the Health Insurance Act. That regulation can be repealed at any time, it's not a statutory amendment, and that's why it's not in the bill, because it can be done by a regulation change.

The Acting Chair: If we're going to be able to have the slide presentation and time for questions, I'd like to begin now if that's all right with everyone. If you could keep the slide presentation to about 10 minutes, then we will have some time for questions before the first presentation at 1:30.

Mr Quirt: While we're getting ready I'll reintroduce Jean McCartney, who's the manager of program design in the policy branch, and also Louise Hurst, who is handling the slides, who's been responsible for the preparation of much of the material that you have before you.

1310

Ms Jean McCartney: Geoff, do you want the working group one or the eligibility one first?

Mr Quirt: I think the working group one, very quickly.

Ms McCartney: Ladies and gentlemen, I will just provide you with a very quick update on some of the program design activities that are under way. Last year, last August, we distributed a document that was called Community-Based Services Provided by Multi-Service Agencies, and in this document we identified many directions that we were interested in pursuing. Now, this particular document is being duplicated and will be made available to you. A lot of our working group activity, though, relates to some of the activities we introduced or some of the ideas we introduced in this manual.

First of all, I'll just outline some of the working group activities under way. First of all, we have the nurse continence advisory service. This is a project to design a training plan for a provincial nurse continence advisory service within the long-term care system. We have transportation, adult day program, meals and services, homemaking. These are separate working groups that are designed to undertake program design and more detailed program development of these particular components of the system.

Other working groups feature the role of the volunteer in the long-term care system and also a working group that is directed to study the consumer fee system that should be introduced. Support to care givers and care giver compensation are working groups that have also started up. This is to look at better ways to support care givers in the care giving role.

Last but not least, we are starting to do the design work. One working committee is working on the MSA program design. This looks at issues associated with eligibility, appeals, service allocation criteria, prioritization

criteria, some types of program accountability structures. Another working group has commenced that looks at MSA policy from an administrative point of view. This is examining the roles of boards, the functions and responsibilities of boards, and funding.

Now, one of the reasons why at this point we're targeting in on these areas is a lot of the community support policy development was not developed in this book. We sent this out, identified some of the questions we needed some responses and some information on, and now with working group activity we're further developing those components. Neither was the whole issue of case management and eligibility addressed in the context of this manual as well. So these are things that are being developed and undertaken by working groups right now.

That is a very quick summary of the program design activity as it associated to work that was done.

The Acting Chair: I just want to point out to the members of the committee that under tab I in the very extensive ministry briefing book that you received is the information that has just been referred to.

Mrs Sullivan: At least two days ago in hearings the committee asked for copies of the manual, and I'd like to be assured that we would have those very quickly, because we are dealing already in the public hearings and want to understand what some of the intervenors are describing, and much of the information comes directly from the manual. I'd like that manual right away.

Mr Jim Wilson: Yes, that should have been sent to the critics of the opposition parties when it was released to the public.

The Acting Chair: Your protest is noted.

Mr Jim Wilson: Thank you.

The Acting Chair: Can we continue with the presentation, please.

Ms McCartney: The next part of the presentation has to do with eligibility criteria, and what I will very briefly do is outline some of the existing eligibility criteria and the problems that have been posed for community-based services before moving into the eligibility criteria that are proposed for the future.

So first of all, there are the eligibility criteria for the existing home care services. I think we're all pretty familiar with the services provided by home care. They're listed here, and you can make reference to them later on in the presentation. But let's look at the specific eligibility criteria in and around home care.

I haven't included all of them here, but two main points are that it's insured under the Ontario health insurance plan and it's under the medical supervision of an attending physician.

This means a physician has to refer a client to the service in order to receive service. For the acute home care program, the person needs at least one of the professional services, such as nursing, physiotherapy, OT and speech therapy. For the chronic home care program, they need at least three visits per month of one or more of the criterion professional services. Now, after the first month, no minimum visit frequency limit applies. However, to get on the program, somebody must continue to

meet the three professional visit criteria.

Now, some problems have come about as a result of that. First of all, until the introduction of the integrated homemaker program, homemaker services were not provided unless the person needed professional services. For acute home care, this was about 80 hours per episode, and for chronic home care if you required professional services, you could get 80 hours the first month and 60 the next.

Another problem was that nutrition and social work services were not provided unless the person needed one or more criterion services. That meant if you needed the services of a dietician, you couldn't get them unless you required the services of a nurse, for example, or a therapist. A major problem also has been that physician referral was required, even if the services provided did not require physician orders.

Then the integrated homemaker program was introduced. Now, this provided housekeeping, marketing, meal preparation, laundry and ironing and personal care. The home care program was targeted to everybody in the province if you met the general eligibility criteria. This homemaker program enabled the provision of homemaker services to some client groups without the provision of professional services. So the eligibility for this program is that the person requires assistance with both personal care and homemaking, the care provider needs homemaker assistance to continue providing care to a sick or disabled person and the care giver is unable to provide care as a result of illness or hospitalization.

Now, this did solve the problem pertaining to seniors who required homemaking service as well as adult persons with disabilities, but some persons are still having to get professional services if they do want some homemaking services. For example, since I am neither elderly nor disabled, if I was leaving a hospital and required homemaker services, I would not be able to obtain them under that particular program.

Another program we have in place is the homemakers and nurses services program. For that specific program, the eligibility criteria are as follows:

- You must reside in the municipality where the person resides for service.

- It's a needs-tested program. That means that generally low-income people have been able to benefit from the services of this program.

- Physician certification is required for the nursing services that are offered by this program.

- It is also offered on a discretionary basis and is cost-shared with the municipalities.

- It's targeted to seniors, persons with disabilities, ill or convalescent persons so they can remain at home.

Home support services, on the other hand, offer a varied number of services. I can't really tell you what the eligibility criteria are for each of these services because many of them have been developed on their own and in keeping with local needs.

Attendant care outreach service provides attendant services to individuals with long-term physical disabilities in their homes. Up to 90 hours, 120 hours in some

circumstances, can be provided. The emphasis here is the provision of personal support, although some limited homemaking services may be provided. It's targeted to individuals 18 and over, though the primary users are the non-aged physically disabled.

Those are the five or six programs that we have operating right now in the community-based setting. Now, I would like to talk about what we are moving to in the context of multiservice agency program delivery. This is a draft, and it is a draft that we will be discussing with the working group to determine how they feel about this specific approach.

First of all, we're trying to move away from a program approach. We're essentially looking at a person's need for service. For example, if you're eligible for home care, you're often eligible for a whole host of services, but under this what we are looking at is eligibility in the context of just a minimum of one service if that's the only one you need. We're moving away from age distinctions and some disability distinctions that have characterized some of the eligibility criteria for our other programs.

1320

So what are our broad eligibility criteria?

- (1) First of all, the person should be an insured person under the Health Insurance Act. This is to demonstrate a residency requirement, that is, the person is a Canadian citizen and resident in Ontario.

- (2) The second point is that the person is appropriately served in the service delivery site. This essentially means that some types of support and care cannot be provided in some types of settings, particularly if you're talking about specific types of equipment to support a nursing need.

- (3) Assessed needs that can be met by one or more services provided by the multiservice agency. So here we're looking at the client has to have one need or two needs, or whatever, that can be met by one or more services. So we're looking at the need for the service. For example, if you needed a dietician for a nutritional assessment, that is what you could get from the service. Getting a dietician would not be dependent upon your need for nursing or therapy.

- (4) Needs cannot effectively be met by other resources in the community or by other programs where they are appropriate and where they exist.

Now, I'm going to chat about criteria 3 and 4 in a little more detail because they're important.

What do we mean by "assessed needs"? First of all, the person must need the service, and need is reviewed in the context of the person's condition and the support available to him or her. So a person may well have a need but the need is not so great that he or she may get the service requested.

So, how do we approach this? Well, we're looking at developing service allocation criteria to determine who will get some types of service and the conditions under which the service may be provided.

What's an example of the type of service allocation criteria we might be developing? I've used homemaking

services here as an example. First of all, we've indicated that free homemaking is provided when it is essential to maintain somebody in the community and avoid admission to a hospital or a long-term care facility.

Now, as a general rule, for such services provided in the community to be very effective in targeting the people where it is most essential to provide the service to prevent admission to facilities, we're looking at persons with multiple care needs or care providers who are looking after people with multiple care needs; we're looking at post-hospital discharges, or what we've termed here is hospital diversion programs—that could be you might get a procedure performed in an outpatient department but need some support when you go home; it could be part of a quick response strategy or a crisis support package—and lastly, persons who have lost the capability to manage.

We do know that the research indicates that the majority of people going into long-term care facilities have a need for a high degree of personal support, may have mental or cognitive impairments, may be incontinent and may have chronic illnesses. So these are some of the factors we've looked at when we try to design community-based services.

Now let's see how these service allocation criteria could be interpreted. Who might get homemaking assistance or be considered key priorities for service? First of all, care providers who require this assistance to continue to provide support to family members at home; persons who have a high degree of personal support need. This is often an indicator of the fact that they cannot provide or undertake their own homemaking task. This does not mean, however, that if you have a personal support need you automatically get free homemaking if you are capable of undertaking it.

I already chatted about support for post-hospital and hospital diversion programs.

We would also like to see homemaking most appropriately utilized in crisis support for individuals where care provider arrangements have broken down and somebody needs to go in on a short-term basis.

I talked about people who have lost the ability to cope. This could perhaps be persons with cognitive impairments, people with limited coping skills or sometimes individuals with reclusive lifestyles. Essentially, we're talking about a client group that has lost the capability to manage as well as they did beforehand, and last but not least, teaching, teaching somebody the functions associated with homemaking, as that provision exists in the act.

I'll now proceed to the last component of the eligibility criteria. That was in determining eligibility looking at what might be available from other government programs. It's very important we do this as part of the eligibility determination process, as this is to try and ensure the fairest utilization of resources and, in some ways, to look at services that may be available to that person from other systems, so you don't have one person who is very overserved because they're getting service from two or three different systems as opposed to one who is primarily getting their service from the long-term care system.

So, as part of the eligibility criteria process, we review the availability of services available from other resources and government programs. We'd look at: Are there any like or similar services provided to persons from the mental health system or the system for persons with developmental handicaps? Now in this document *Community-Based Services Provided by Multi-Service Agencies* we did do an initial cut of what we thought these systems should provide vis-à-vis the long-term care system, and that is additional work that will be undertaken in the weeks ahead, a further refinement of those activities and where joint collaborative action is possible.

There could be programs in the community where some services are already provided by the multiservice agency but onsite. An example here is support service living unit programs for persons with physical disabilities. They receive attendant care onsite and homemaking assistance onsite. Therefore, it would be inappropriate for the multiservice agency to provide those services to people in those settings but appropriate to provide professional services which are not available.

Programs provided by other community resources: When eligibility for multiservice agency programs is determined, it is part of the assessor's job to determine whether this person might be more appropriately served by a hospital outpatient department if they offer that specific therapy service. So, if such a resource exists, it's effective in meeting the person's needs, then that could be suggested as an alternative.

Lastly, programs that the client may have access to that are offered by other provincial ministries or the federal government: Again, this is looking at the resources and support that may be available to a client that others do not have. An example here might be somebody who is receiving an attendant care cash allowance from workers' compensation. It's only one example.

At any rate, ladies and gentlemen, this brings to a conclusion a very fast and quick overview of eligibility then and proposed.

The Acting Chair: Thank you very much. I want to remind committee members that we have over two weeks yet of hearings and opportunities for questions to be answered by ministry officials. In order to make sure of our priority, which is to hear the public and the deputations today, I'm going to ask that you make note of any questions you have.

ONTARIO DENTAL HYGIENISTS' ASSOCIATION

The Acting Chair: It is almost exactly 1:30, and I'm going to ask the first deputation of the afternoon to come forward. You have received, I believe at the last meeting, the submission from the Ontario Dental Hygienists' Association. You should have it with you now.

I'd ask the Ontario Dental Hygienists' Association to please come forward. Welcome. You have 20 minutes for your presentation. I'd ask that you introduce yourselves to this committee at the beginning of your presentation. If you'd like to leave some time for questions, that's fine; if not, the time is yours. Please begin.

Ms Elizabeth Craig: Good afternoon. My name is Elizabeth Craig. I'm the executive director of the Ontario

Dental Hygienists' Association, which is the voice of the profession of dental hygiene in Ontario.

Mrs Sullivan: Point of order, Madam Chair.

The Acting Chair: Excuse me. Yes?

Mrs Sullivan: Is there some way that the volume can be turned up so that we can hear the deputation?

The Acting Chair: Just before you begin, while they're turning up the volume, I have an answer on the request for the manual. If you'll tell Geoff where you'd like it, it can be delivered to you tomorrow. Okay? Thank you for that prompt reply, Mr Quirt.

Please begin again.

Ms Craig: Okay. Is that all right now? Can you hear me better? My name is Elizabeth Craig. I'm the executive director of the Ontario Dental Hygienists' Association, the voice for the profession of dental hygiene in Ontario. The profession now numbers almost 5,000 practitioners. Membership in the association is voluntary and presently represents about 54% of the registered dental hygienists in the province. I believe that our written submission has already been circulated to you.

1330

The Ontario Dental Hygienists' Association agrees with the purposes specified in Bill 173 regarding long-term care and applauds the government's efforts to better meet the social and health needs of recipients of long-term care. Our presentation today may well be a departure from many of the others that you have heard thus far. We wish to discuss not what is contained in Bill 173 but rather what is not.

The ODHA understands that Bill 173 represents a reorganization and coordination of services already provided through the ministries of Health and Community and Social Services. The ODHA also understands that dental hygiene was not part of the previous menu of services and therefore has not been included in this act as one of the professional services listed.

When the Minister of Health, Ruth Grier, introduced Bill 173 in the Legislature, she described it as a commitment to "improve and expand long-term care and support services." The ODHA suggests that the inclusion of dental hygiene services would significantly improve and expand the level of service provided to long-term care clients.

As you know, dental hygiene is one of the 23 regulated health professions. Having just gone through the process leading up to the enactment of the Regulated Health Professions Act, we cannot help but note the similarity in many of the principles of both the RHPA and those of Bill 173. Both speak of placing the consumer first in terms of providing them with a full range of services, having control of the choice of care to be received, having access to that care and receiving quality care.

Dental hygiene was seen to espouse these principles as they applied to regulation of the profession, but the profession is notable in its absence from Bill 173.

In its publication, *Health Times*, the Ministry of Health defined dental hygiene as follows: "Dental hygienists assess the oral cavity and provide preventive, educational,

clinical and therapeutic services in a variety of practice settings." We believe this is an accurate and succinct statement of the profession's *raison d'être*.

Again, it uses key words which are also implicit in the principles behind this redirection for long-term care, words such as "prevention," "education," "therapeutic services" and "variety of practice settings." There is a clear match between the purposes of Bill 173 and the practice of dental hygiene.

Ms Linda Berry: Good afternoon. My name is Linda Berry, and I am the government relations chairman for the Ontario Dental Hygienists' Association.

Over the years, it's been a source of concern and frustration for our organization to know that many segments of our population are unable to access dental and dental hygiene services. One of the outreach programs which we did conduct was to produce an oral hygiene presentation called *Senior Smiles*, which received funding from the Ontario Ministry of Health. This presenter-friendly program has proved to be a most useful tool in promoting dental health to the elderly. However, this and many other well-meaning programs conducted by dentists and dental hygienists across the province are but a drop in the bucket in addressing the dental needs of those in long-term care.

A number of dental public health units, notably North York, Simcoe county, Muskoka and Ottawa-Carleton, have extended their existing dental public health programs to include some services for residents in collective living centres. However, lack of funding has prevented the expansion of these programs even though they have set an example of what can and should be done in terms of oral health care.

Is there a need for dental and dental hygiene services in long-term care? Well, we could have brought along this afternoon some slides that could have graphically shown you cases of neglect, cases of oral cancers undetected. We could have brought along dental hygienists who are currently conducting research or are providing care for the elderly, who could have described for you the sorts of situations that they're seeing. However, realizing that we followed perhaps a lunch break, we did not do that. However, I think that most of you have had an opportunity to visit seniors' residences of some sort, and in meeting with the residents there you have seen the outward signs of their oral condition and can only half imagine what the dental needs are that go on behind.

The goal that should be achieved in oral health care for long-term recipients is not to give everybody a Hollywood smile; it is much more basic than that. It is to ensure that each of them is able to properly chew their food; that they are able to eat a variety of foods for proper nutrition; that they are able to speak properly, to enunciate and communicate; that they are able to smile and socialize with others; that they are able to control bad breath; that they're able to wear their dentures and to have those dentures function; and that they are free from pain. All of these factors impact not just on their dental health but their overall health and indeed on their quality of life.

Is oral health care receiving adequate attention right

now? Dental and dental hygiene services in long-term care facilities are extremely limited, often only providing emergency service. Dental care for any in group homes or those being maintained in their own homes is virtually non-existent.

Factors contributing to this low level of dental oral care are some of the following: Most dental and all dental hygiene services are of course not covered by OHIP; most long-term care recipients no longer qualify for third-party insurance coverage to assist with covering the cost; facilities do not allocate an appropriate amount of their budget for dental facilities, and those dentists who do attend usually do so on a very sporadic basis or for emergencies only; dental hygienists, unless part of a public health program, are severely limited by legislation in the services that they are able to provide.

Add all of these factors to the fact that many long-term care recipients are no longer capable of providing an adequate level of daily care for themselves, or that their care givers lack the time, the knowledge or the resolve to ensure that oral hygiene is looked after each day. The end result is that perhaps the segment of our population most in need of dental services is receiving the least.

In addressing this situation, the Ministry of Health and the Ministry of Community and Social Services have adopted standards and criteria for both the daily provision of care and for dental services that should be received by those in long-term care facilities. This, I believe, is contained in the manual that you've been talking about. The ODHA believes that these standards and criteria should apply to all long-term care recipients regardless of whether they reside in a regulated facility.

The ministry's recognition of oral care in those guidelines, coupled with comments made from seniors' groups, from care givers such as the practical nurses, confirm in our mind that oral care should have been a specified part of Bill 173. We had hoped to have in attendance with us today representatives of the Ontario Society of Public Health Dentists. Unfortunately, they have not arrived yet, but I would add that they are pleased that we have had the opportunity to speak with you and that they would support the statements that we have made.

Mr Jim Wilson: Would you like to comment on something that's raised on page 9 of your brief, the 20% rule. Given that, under the scheme so far anyway, Bill 173 won't be part of the MSA 80% service model, the services you point out will have to be contracted out at the 20% barrier, which would actually, I think, act as a deterrent to future growth or expansion of dental hygiene in community-based programs. Do you want to comment on that?

Ms Berry: We certainly see dental hygiene as an appropriate practitioner in providing dental care, and the services that they provide will go a long way in contributing to the quality of life of these individuals. If that service has to be purchased within that 20% cap, and other services as well, it's going to dilute a great deal how much dental care can be provided under that 20% cap.

Mrs Sullivan: I appreciate your presentation, and I

think that, as have others, you've identified an issue that is of some concern, and that is where the clinical assessment and service delivery fits. For myself, I think it's useful to have a defined basket of services that are the minimum services across the province that those who seek long-term care should have. Certainly, we've heard from the medical community and from the RNAO that the assessments should include medical services, and I'm glad to hear from you that dental and dental hygiene services should be included in the assessment of needs as well.

I wonder if ministry officials or the parliamentary assistant could indicate to us why the clinical areas are not required or referred to in the bill at all. Is it simply a matter of a difference in the route of compensation of those kinds of professional services, whether they're medical or dental?

1340

Mr Quint: If I might, I'd answer that in two ways, by first of all talking about your concern about clinical assessment. The bill does talk about assessment as one of the necessary components of case management. The bill does reflect, however, a wide difference of opinion as to how much assessment a client requires prior to a particular service being delivered, and it also tries to account for wide variation in opinion about the necessity of health care assessments for individuals.

As we've pointed out before, if the needs of a client warrant, a very complicated, comprehensive assessment would be necessary involving the appropriate health care professionals, physicians and nurses and clinical specialists and so on. However, when it comes to support services, often people representing the community of folks with physical disabilities argue that they have absolutely nothing wrong with them from a health point of view and are quite happy to make their own assessment about what supports they need to live on their own. So the bill tries to accommodate both perspectives and be flexible in terms of the assessments required.

I think the issue that you've brought before us today boils down to one of financing dental care for people who can't afford to pay for it. Clearly, referrals to a dentist or a dental hygienist would be a very appropriate and often expected referral to be made by a multiservice agency or public health nurse or other person in the community service field.

I think the problem we encounter is when people live in a long-term care facility, who do have a right to regular assessment, they may still have difficulty in affording dentures or particular dental treatment, and those in the community as well face a financial barrier in some situations. I'm sorry to say this bill doesn't do anything to address the financing of dental care for those people who don't have third-party insurance or who are not recipients of public assistance, for example, GWA or FBA, that does cover that type of expense.

The Acting Chair: Thank you. There are no further questions, but there are a couple of minutes if there's anything further you'd like to say to the committee to wrap up.

Ms Berry: Just in response to the question, first of all, about assessments, I might read to you from the guidelines that have been developed, or the criteria, which referred to assessment in two places: one, that new residents shall have an oral assessment as part of the admission, medical and nursing assessments—so it is addressed there—secondly, that a dental assessment and preventive services shall be offered annually or as required by qualified dental personnel. So dental assessments have been addressed in the manual.

Mrs Sullivan: In the manual for long-term care facilities?

Ms Berry: Yes.

Mrs Sullivan: For facilities, but not for community-based services.

Ms Berry: That's what we're saying here, that we feel it should apply to everybody, not just those in facilities.

In the point about financing, I think what we wanted to stress is the fact that dental hygiene is a very cost-effective way of providing dental care. There is a great deal that dental hygienists can do in a facility where you wouldn't have to refer them out for services, where they could work with the residents themselves both in education in developing daily programs that could help to maintain their oral health and providing therapeutic care if necessary, as well as working with the care givers so that when they can't be there day to day, they can work with the people who are there to try and bring their oral daily care up to an effective level.

VICTORIAN ORDER OF NURSES:
GUELPH-WELLINGTON-DUFFERIN BRANCH,
HALTON BRANCH, NIAGARA BRANCH,
WATERLOO REGION BRANCH

The Acting Chair: Our next presentation is from the Victorian Order of Nurses, Guelph-Wellington-Dufferin branch, Halton branch, Niagara branch and Waterloo region branch.

The agreement that has been made, because these are four separate branches of the same umbrella organization, Victorian Order of Nurses, is that you'll have up to 40 minutes for presentation and questions. We can pull as many chairs up as you require. I'm sure you've decided who your lead is, but it might be a good idea if perhaps you could introduce everybody who's with you, and then as a person speaks they could just state their name and where they're from exactly for the purposes of helping out Hansard. Welcome. Please begin your presentation now.

Ms Cherry Cross: My name is Cherry Cross. I'm a vice-president of VON Halton's board of directors and I will be acting as spokesman today, with some expansion on my theme by Dan Toppari, past president of the board of directors, region of Niagara.

The other members of our delegation today are Carolyn Milne, executive director of VON Halton; Jan Lord, executive director of the Guelph-Wellington-Dufferin branch; Cori Phillips of the Victorian Order of Nurses, Guelph-Wellington-Dufferin; Dan Toppari, as I mentioned before; Mary Casey, president of the board of

directors of Waterloo region branch; and Elizabeth Allan, executive director of Waterloo region branch.

Our plan this afternoon is that I will briefly go through the proposal that you have in front of you and then be available, board members for perhaps questions around the issues of governance and volunteerism, and the executive directors perhaps around our operational matters.

As an introduction, VON, both Guelph-Wellington-Dufferin, Halton, Niagara and Waterloo branches, appreciates very much the opportunity today to present our joint submission on Bill 173 to the standing committee on social development.

VON is a not-for-profit voluntary health care organization that addresses health and social support needs of the people of Ontario through services provided by nurses, other health professionals, home support service workers and volunteers.

We are four of the seven branches in the south central region of VON Ontario, and we represent a total of 750 employees and 770 volunteers. All of the four branches provide visiting nursing services 24 hours a day, seven days a week, to their local home care programs, as well as service to individuals within the communities they serve.

In 1993-94, over 500,000 visits were made to over 21,000 clients. Two branches—Guelph-Wellington-Dufferin and Halton—operate Alzheimer day programs, friendly visiting and hospice volunteer visiting. Guelph-Wellington-Dufferin branch also provides homemaker services to the home care program for both home care and the integrated homemaking program. In 1993-94, approximately 150,000 hours of homemaking were provided to over 1,600 clients. As well, each of the four branches involved in today's presentation operates foot care clinics throughout their respective geographic areas.

1350

VON recognizes the need for reform and is actively involved in the collaborative planning required to implement and enhance a community health and support system that will be able to provide a quality continuum of care within the limited resources available.

We're going to focus our brief on three specific issues: first, a lack of flexibility in governance, uniform rules and procedures, and assessment and eligibility; second, the area of human resources; and third, the area of funding.

I'd like to address first the area of flexibility. This legislation will need to carry us through times of very rapid change and therefore needs to allow for a high degree of flexibility. In its current state, we find sections in the act that tend to be prescriptive rather than enabling.

It would appear that it is the intention of the government to create multiservice agencies province-wide that will result in the total amalgamation of agencies that provide community-based services. For example, there's an important need for flexibility in the implementation of the MSA and the opportunity for communities to develop models that meet and reflect their unique needs. We are recommending that the province accept alternatives to amalgamation, as arrived at by individual communities,

that may include a federation of agencies or other models which will achieve a multiservice system and also achieve the goals of long-term care reform.

From the consumer's perspective, there's an urgent need to integrate at the front-line level of service delivery and simplify access to the needed services. There's no doubt that service providers can work as a team, sharing common assessments, charts, care plans and values. Through these efforts, duplication can be eliminated and better coordination can be achieved. Already in many of our branches, interagency committees have been established to immediately tackle these issues.

To our knowledge, we've not seen any evidence that integration and/or amalgamation of service providers in a single agency will result in any savings. It would seem that Ontario is going in the opposite direction to many countries such as Great Britain and Sweden, where an integrated approach has been tried and abandoned. I'll refer you to the Thames Valley District Health Council discussion paper of January 1994. Also at risk would be a potential loss of thousands of volunteers, an essential human resource in our community programs.

We respectfully recommend that the standing committee on social development support our request for flexibility by amending part VI, subsection 15(2) to remove the four-year limit on transition to a fully amalgamated MSA.

As for uniform rules and procedures, VON supports the purposes of the act as outlined in part I. However, we are concerned that the application of uniform rules and procedures, clause 1(e), may negate the purpose "to recognize the importance of a person's needs and preferences in all aspects of the management and delivery of community services." We support the application of consistent eligibility criteria but believe that rigid rules and procedures must be the exception, and flexibility the rule.

Specifically on assessment and eligibility, VON supports the need for an eligibility test for service provided by the multiservice agency. Subsections 20(1), (2) and (3) of part VII of the act, describing rules governing approved agencies, imply that there will continue to be a high degree of bureaucratic rigidity. This appears to be built into the act's requirements for an assessment of need before eligibility is determined. VON believes the client's own assessment of need for service such as Meals on Wheels or home support should initiate the assessment process. Nowhere in this section of the act is the client described as having any input into the development of a plan of service or is able to determine his or her own service requirements. Clients of VON continue to express their frustration with rigid and unnecessary application of rules and procedures applied in a paternalistic fashion.

Centralized telephone intake utilizing a risk screening tool could allow for the separation of clients into those whose needs require no further formal assessment or service plan than that identified by the client. Other clients could be referred for in-depth assessment. Electronic databases within the MSA with providers on-line could further avoid duplication of information collection and assessment.

VON recommends a less obtrusive system of self-reporting eligibility and self-application for services

where this is possible. We also recommend the introduction of assessment and service planning, ie case management, for complex cases requiring clinical as well as resource service coordination and planning.

Human resources is another area that we feel strongly we would like to address today. Other concerns we have relate to the need for protection of current staff jobs. VON, along with its other long-term care community health and support service partners, has requested from the ministry protection for non-union staff similar to the protection afforded under successor rights in the Labour Relations Act for unionized staff. We are requesting that the committee make a strong recommendation on behalf of non-unionized employees for equal protection with unionized employees as this new system is created. VON and the other providers are asking for equal opportunity for all employees in accessing jobs in the MSA.

Severance costs: Unless jobs are protected, severance costs for non-profit long-term care community agencies could be significant. In contrast to for-profits, all moneys of not-for-profits are returned to service in the community, and thus few organizations have equity to pay severance. We recommend that if severing employees occurs, the government, having brought on the said situation by the legislation, should reimburse these agencies for severance.

As to the issue of board appointment, we're recommending that subsection 4(1) be amended to remove the minister's power to appoint directors and that the MSA board have full accountability and responsibility for board recruitment, selection and nomination. There's a strong perception that the MSA will be a bureaucratic government agency rather than a strong community-driven organization. We believe boards will responsibly select and develop their directors to govern the MSA and that the government should remain at arm's length in this process. This is consistent with the belief that the MSA can be an effective community-based organization.

1400

The issue of funding: In the explanatory notes of the Long-Term Care Act, 1994, it states, "The Health Protection and Promotion Act is amended to delete a reference to home care services under the Health Insurance Act because these services will be encompassed in the new scheme for the provision of services under the bill." This explanatory note implies deinsuring of home care services. Currently, the costs of home care services are known and are paid for with OHIP coverage. VON is concerned because the new legislation gives no guarantees of adequate funding for the services to meet the client's needs. The government has eliminated a current safeguard and replaced it with an unknown. If there is not adequate funding for the MSA services, the community health and support system can expect long waiting lists and the further development of a two-tiered system. VON believes funding is a serious issue and recommends that the committee address this issue in the legislation.

At this time, Dan Toppari is going to address the issue of volunteerism as it applies to the act.

Mr Dan Toppari: Madam Chair, honourable members, ladies and gentlemen, I do not pretend to know all

the issues surrounding Bill 173 and the reform of long-term care. The focus of my presentation will be on what I do know about, and that is volunteerism. If there is such a thing as an expert volunteer, I'm probably close to being one. I have been volunteering for over 20 years, everything from minor sports to service organizations to the Victorian Order of Nurses. Last year I was presented the Canada 125 medal in recognition of my volunteer activities. Maybe that qualifies me as an expert volunteer.

Why do I volunteer? I am not wealthy, so why do I work for these organizations for no pay? I have many time-consuming activities, including a young family, so why do I sacrifice my precious time? Why? Because I feel that I am accomplishing something worthwhile with my volunteer efforts, and I like that feeling.

Without exception, I became involved as a volunteer for a particular organization because someone I knew and respected encouraged me to do so. In every case, it was a combination of that respect and the intrinsic value of the particular organization that led to my volunteering.

When I was asked to volunteer as a board member to the VON Niagara branch some 10 years ago, the person who encouraged me to join had himself been on the board for over 10 years. I was honoured at being asked to join one of the best-respected health-related institutions of our country, with its origins dating back to the last century. Over the last 10 years, my time involvement with the VON has fluctuated. However, when I was president, I was very busy with the VON. I averaged between five and 10 hours per week, mostly at meetings, as well as events and presentations. Across Ontario there are thousands of volunteers like myself helping the Victorian Order of Nurses. We are paid not in dollars but, to us, in more valuable dividends such as pride in this institution which we have worked so very hard on behalf of.

What hope do multiple service agencies have at recruiting volunteers of like quality and quantity as those now helping community care organizations in Ontario? They don't have a prayer. They don't have a stock of current volunteers to encourage others to join. They don't have the attraction of a long and rich history. They don't have the appeal of an institution that absolutely needs its volunteers to exist.

I encourage the members of this committee to support long-term care reforms that will not destroy the identity of the individual organizations, so that volunteers like myself can continue to feel good about the work we do and so that the people of Ontario will continue to benefit from our time, freely given.

For our concluding statement, I'll return the floor to Ms Cross.

Ms Cross: In summary, we're very committed to the principles and ultimate goals of the government's long-term care policy. We strongly support the need to further develop a cost-effective system that will increase consumer participation in decision-making, simplify access to service, reduce duplication and improve the coordination of service. Your attention to the issues we have brought forth today will assist to develop a strong, effective and responsible long-term care system.

Mrs Sullivan: I want to say, I think from all of us on the committee, that we appreciate this brief. From my point of view it's a very succinct appraisal of what the difficulties are that will be faced by people, frankly, who will be attempting to seek services and by those who are employed now in the current system, either as workers who are paid or as volunteers.

I think you've pointed out quite clearly that what people want is a multiservice system, not a multiservice agency, not a single monopoly bureaucracy that is put into place to do all of the work that you do and more than that.

You have raised the issue of severance. We have had, in fact, no indication from the government of what its intentions will be with respect to compensating those agencies whose employees will no longer find a place in the system, because the VON will disappear. I would like to ask the parliamentary assistant what the government's intentions are with respect to severance and also what the government's intentions are with respect to those capital effects and compensation for those capital effects that are now owned and used by organizations such as the VON, including, by example, their automobiles and other equipment they use daily to do their work.

Mr Wessenger: I'll perhaps make a preliminary comment with respect to that. I think it should be understood that the process with respect to the whole question of human resources is to be dealt with by the local MSA, and the direction that will be given to that is to bring in a fair human resources plan which will deal with all employees fairly. I also would hazard to say that this matter will also have to be dealt with in respect to the whole question of assets and how they're dealt with.

Mrs Sullivan: Point of order: How can a local MSA deal with the human resources—

The Acting Chair: That is not a point of order. That is a question.

Mrs Sullivan: Okay, a question, then. How can a local MSA deal with human resources of an agency which it has put out of existence? What responsibility will an MSA have for the VON employees?

Mr Wessenger: I think it's been fairly well indicated that the local MSA will be directed to bring in a plan which will ensure that employees who work in the community sector are dealt with fairly with respect to the new operations, and anticipate there will be no loss of employment with respect to the people providing services. Perhaps I'll ask the policy person—

Mrs Sullivan: Do we have a guarantee of that?

Mr Wessenger: —to add more details to this, but that's certainly my understanding.

Mr Quirt: Just to clarify that a bit, the district health councils, in developing their recommendations to the minister for multiservice agencies, will be required to submit proposals for multiservice agencies. The minister has made it clear that in those proposals there has to be a human resource plan that adequately addresses the issue of job security for front-line workers. It is our expectation that the government will be funding more direct service jobs, not fewer direct service jobs, with the advent of

multiservice agencies, given that we are making a substantial investment in direct services.

In the event that an employee of an existing agency either is not able to accept a job with a new multiservice agency, chooses not to, or is not offered a job with a new multiservice agency, then the costs associated with the severance of that individual would obviously be a government responsibility, given that you don't have the resources to pay for it otherwise and it's our policy that has required you to take that action.

Secondly, with the small number of employees that we hope are affected negatively by this—noting that we expect thousands more jobs as opposed to the opposite, but with those small number of employees affected negatively—we hope the resources of the health sector training and adjustment panel would be available to them. As I said earlier, the long-term care redirection is a job creation initiative, not a job reduction one.

The Acting Chair: Mr Wessinger next to make a statement and clarify, then Mr Jackson. Then, time permitting, there's another question possible from the Liberal caucus, one from Mr Malkowski, and then Mr Jackson.

Mr Wessinger: Just to make some clarification with respect to some of the comments in the brief, first of all, with respect to the comment concerning the client not having input in the development of a plan of service, if you'll look at section 20(3), you'll note that "An approved agency shall provide an opportunity to participate fully in the development and revision of the plan of service" to the person who is the subject of the plan or service, so it is clearly provided in the legislation for that client input into the development.

Secondly, there is a misunderstanding with respect to your comments on page 7. Subsection 4(1) does not in any way relate to a director of an MSA. It purely relates to the appointment of a director in the ministry. The MSA board will have full accountability and responsibility for recruitment, selection and nominations, so there's no appointment by the government of either any employee of the MSA or any directors of the MSA. It's a non-profit corporation. It will just like the VON does now, very similar. In fact, the VON could conceivably be an MSA.

1410

The Acting Chair: Would you speak directly into the microphone and state your name, please.

Ms Cori Phillips: Cori Phillips, with the Victorian Order of Nurses, Guelph-Wellington-Dufferin, and currently serving in the capacity of president.

Perhaps, Mr Wessinger, that should be clarified in the legislation, because currently, as it stands, there is great concern within the communities and on governing boards that there is the opportunity for the ministry to appoint people to what is supposed to be a community-based board. Obviously, your conditions and limitations that are set out further on in that section, I realize, must apply to a directorship, but what is the position of the ministry if an MSA is unable to meet all the requirements as set out for the directorships on the MSA boards and should they

not have sufficient numbers? We have no indication at this time as to what numbers you're looking for in terms of board representation.

Within the community that I'm currently serving in, we may have upwards of 100 people serving on a variety of community-based boards. With the advent of the MSA, I would foresee that this number will drop to perhaps 20 at most, so we will lose the expertise and skill and experience of many people within the community who have devoted a great deal of time to making their community better in the delivery of health service. We just want some assurances that the ministry is not going to be able to turn around and tell us, "This person is not appropriate" or "That person is not appropriate." And what are the numbers going to be?

Mr Wessinger: I can assure you that's the case, but I think ministry staff, Mr Quirt, could probably elaborate further on that with respect to the progress being made in that area.

Mr Quirt: Yes, it certainly hasn't been contemplated that the minister would say: "Sorry, I don't like that person. Would you please have this other person on your board of directors."

Mr Jim Wilson: They do it on police services boards and other boards all the time.

Mr Quirt: It's not contemplated for the multiservice agency. The director—

Interjections.

The Acting Chair: I'm going to ask for order, please, so we can hear Mr Quirt.

Mr Quirt: The "director" referred to in the act refers to currently about 17 or 18 people within the Ministry of Health bureaucrats who make particular decisions if the minister so chooses to designate authority to them. I think you're absolutely right: If that's the impression the act leaves, then we have goofed in creating that impression and we need to clarify it.

I'd go on to say that the minister is obliged by the act, when making the decision to approve an MSA, to take into account whether the board is representative of the community it serves from a cultural perspective or a geographic perspective. If you were going to serve a whole county and everybody was going to be from one corner of it, she might say: "Well, wait a second. That's not as representative geographically as it might be." It also requires her to take into account whether it adequately represents the consumers to be served by the service. It doesn't oblige her in any particular way to decide one way or the other; it obliges her to take into account those factors in making a decision. So she has some discretion there.

Secondly, she has indicated that in terms of consumer participation, our guideline might be that at least a third of the people on the board would represent consumer interests. Some presenters have come forward and said it should be 50%, but the minister's position at this point is she thinks that at least a third might be consumers. That, I think, hasn't been adequately communicated to people as well, and I thank you for bringing forward those things that we need to clarify.

Mr Jackson: I can't help but be struck by the fact that it was three and a half years ago that both Carolyn Milne and Cherry Cross were at a meeting that I was at when we were looking at an entirely different model and vision and collaborative approach than what we have in front of us today. It's just mind-boggling to see how 180 degrees different this legislation is from what we were told by civil servants and the policymakers of the day.

Having said that, I concur with the concerns you've raised. Certainly our caucus won't be supporting this legislation without first submitting amendments, at least trying with amendments that cover most of the points you've raised.

The one that is starting to increasingly give me concern is the issue around severance, because severance can be an imposed factor by a government that governs its labour laws. Also, severance could be imposed as a precondition of the purchase of any services by a future MSA. You could literally punch a hole in your asset base and have that imposed, so that it's basically got a gun to your head saying, "If you would like to do business with us, you must provide severance."

I don't think that's going to happen, because there has been one experience in this province under the current government in terms of this transition adjustment. Nobody has been talking about it, but it's how the government handled the conversion of day care centres. Quite frankly, for the non-unionized workers, even unionized workers in non-profit agencies, their seniority in severance was not acknowledged at all by the government. Of course, that's an official position of OPSEU in terms of punishing those workers. That's clearly on the record for them, and I'm fearful that you're vulnerable in these two areas—the sense of devotion you have working with your staff, many of whom are non-unionized, but the relationships are incredibly good and the obligations, moral or otherwise, are very strong as well.

The Acting Chair: Thank you for your question, Mr Jackson.

Would you like to sum up in the minute that's remaining? Anything further you'd like to say?

Ms Cross: The only thing I might want to say is that although there perhaps are some obviously negative feelings around some issues of the act, we as a whole are very, very pleased, because had it not been for Bill 173, perhaps some of the things that are happening in our areas now would not have happened. In other words, it has served as a catalyst to bring about partnerships in community-based organizations that traditionally haven't worked together in the past working together to provide better care for those in long-term care.

We thank you for your time and attention today.

COALITION OF COMMUNITY HEALTH
AND SOCIAL SERVICE AGENCIES
OF HAMILTON-WENTWORTH

The Acting Chair: The next presentation is from the Coalition of Community Health and Social Service Agencies of Hamilton-Wentworth. Please come forward, take a seat, relax, and introduce yourself to the committee. You have up to 20 minutes for your presentation. We

have not received anything in writing. You're aware of that?

Ms Norma Walsh: That's right.

The Acting Chair: Okay, that's fine. It's not required.

Ms Walsh: Madam Chairman, thank you for giving us an opportunity to present today. I'd just like to take an opportunity to welcome all of you to Hamilton-Wentworth and to thank you for making this one of the locations in your itinerary across the province.

The Acting Chair: Thank you. That's a very nice welcome.

Ms Walsh: I am the past chairman of the coalition that is presenting today. Our chairman is on holidays, so he asked me to substitute for him. What we're presenting to you today are actually some thoughts around Bill 173, but it's also mainly to explain to you some of the work we have done in the coalition in Hamilton-Wentworth up until now that relates to the redirection of long-term care.

The coalition represents 21 agencies. You heard from three of those agencies this morning—the VON, the VHA and St Elizabeth—who have been working particularly with their board members around the health and personal support service aspects of long-term care. Our broader coalition relates to everything that deals with services in the community, be they health or social services. We have prepared a model of MSA for our long-term care committee and our district health council that suggests how these services should be delivered in Hamilton-Wentworth and how the whole organization should be governed. We will leave a copy of that proposal with you.

First of all, I want to say that we too espouse the goals and the principles of the province and our local long-term care committee, and our paper makes that very clear. We of course have read all of the reports, the rainbow reports as they're known, and the principles and objectives of Bill 173, and we don't have any difficulty with them.

One of the common denominators that our coalition members have is that we serve seniors, but some of our members also serve other populations that are to be governed by long-term care. We feel the model MSA that we're proposing can cover those who have HIV/AIDS, the physically disabled and brain-injured persons.

1420

What we propose in our model is a federation. That's something that doesn't seem to be allowed through Bill 173, but we feel that through our federation we can provide all those things the government wants to see provided: simplified access, information and referral, coordination and integration of services, the management and service delivery excellence demanded by the community, the eligibility for facilities, and of course the authorization for admission to facilities. The basket of services that we propose will include all of those services covered by Bill 173.

In our model, we centralize some of those programs, the obvious ones that in our community we feel should be centralized, such as PCS, physio and occupational therapies, because those are specialists who are very

scarce. We also centralize some other administrative activities. However, in the main what we're suggesting in our model is that services be delivered through area offices within the region.

None of you are from the Hamilton-Wentworth area, so maybe I can just briefly tell you that the city of Hamilton makes up approximately 70% of the population of our region, and the city of Hamilton is right in the middle of our geographic area. We're surrounded, then, by more rural areas that used to be the old county of Wentworth. For that reason, and because of the history attached to some of the development of programs within those communities, we feel it is very important that the services be delivered on a geographic area-wide basis where people who have been used to identifying with local neighbourhoods can continue to do that, and hopefully the services will become more attuned to what's going on in the neighbourhoods as well. We feel that most of the services can be delivered through these area offices and perhaps also through some suboffices that might exist, and do exist, by the way, in communities such as Dundas, Flamborough and Ancaster.

We spend a great deal of time in our model talking about information and referral because, frankly, we think that's the major problem we have in this community. I think Mrs Sullivan made reference this morning to the fact that our coordinating efforts in Hamilton-Wentworth seem to be known beyond our borders. We're delighted to hear that, because we have worked very hard for a number of years to create that kind of coordination and consolidation and networking among our services. However, we do have a problem with information and referral. It's not a problem that we're totally responsible for, but we do think that's a major area where we must improve our act as community agencies. That certainly would be a major thrust and where we would hope to get resources so that we can develop a one-stop-access situation for the members of our community. I'm not a technical person, but technically I'm told this can be done by incorporating a lot of new technology into our access system. Frankly, that's one of the areas where we want to spend a great deal of time.

The experience of our current information services in the community tells us that they get a wide variety of people calling in, some just wanting information, some who need help in clarifying exactly what it is they do want, and some of course who are phoning in in rather precarious situations and for whom immediate action is requested and necessary. I think the type of one-stop access that we develop would—must, actually—cover all of those situations.

We spend a great deal of time in our document talking about the geographic areas, but these are suggestions. The areas we developed are based upon geography, upon population, and also upon the expected growth in population in our region over the next 20 years.

Around the governance idea, as I mentioned to you earlier, we have gone for a federation model. The federation would not only bring the agencies together in some umbrella organization, but of course there would be consumer representation and citizen representation on a

board of directors of any umbrella organization. It would not be unlike what has happened in the development of the long-term care committee in communities across the province.

I'll leave my part of the presentation at that and welcome Nancy Long—the late Nancy Long—who is a public health supervisor and of course has been working today and who is going to address some of the items that we feel we cannot go along with in Bill 173.

The Acting Chair: Actually, you're not at all late, Nancy. The committee's just been moving along, so welcome.

Mrs Nancy Long: Thank you. Actually, as I was driving down here, I did have that horrible thought that you might be early, and I would be racing in as I was. Thank you very much, though, for allowing us to come and speak with you.

I guess really what I wanted to do was to say four points in closing, or to close Norma's presentation.

One is a reminder of the goals, I think, of long-term care. We've tried very hard in our coalition to keep on reminding ourselves of them. It goes back to a Ministry of Health document which talks about the promotion of health, sustaining wellness, diminishing disability and dependence. I felt it was important to remind people going along with Bill 173 that just a better coordinated system does not necessarily guarantee any of those goals, so it's a cautionary note for all of us. We don't really just want a better coordinated system with a very efficient MSA; rather, what we want is a system that does promote health and sustain wellness within our community.

The second point in terms of our proposing a federation of agencies is that we feel very strongly that this will maintain local identities that our community agencies have realized. We do realize there is a need to amalgamate some of the community agencies and we are very much at the beginning of discussions in terms of what might need to be amalgamated, but we feel we would not recommend amalgamation of all agencies perhaps as Bill 173 proposes.

A concern along those lines is in terms of the governance issue and the use of volunteers. We in Hamilton-Wentworth, as in many other communities, have a tremendous number of volunteers who support our local community agencies. We're very concerned that with the amalgamation we will lose this huge number and the strength that the volunteers give our local agencies. That goes along with sort of the man-hours that they provide, as well as charitable donations that are given to the specific agencies.

My fourth point is with regard to funding. It would appear that through Bill 173 there's a presumption that the funding for local agencies will flow into the MSA. I guess an example of that where we would be concerned would be an agency like Catholic family services, which is currently funded, I believe, 70% through the ministry and 30% through United Way. It would appear there is a presumption that that 30% funding would also sort of flow into the MSA. Quite frankly, I don't think the community agencies are convinced of this, so there's a con-

cern about where that additional funding will come from.

I guess basically, in closing, our consumers are telling us that they need easier access. That seems to be the biggest complaint so far. We feel that through our proposed federation of agencies and improved information and access services, we can address what the consumers are telling us they would like.

I'll close there and thank you very much for the opportunity of coming today.

1430

Ms Walsh: Just one further comment. In addition to the information and access deficiencies of our system, I must bring to your attention that certainly one of the other problems we have is an underfunding of some of our current services. We have a great proportion of our regional population—not a great proportion, but a significant population—who live in rural areas, in Flam- borough and Ancaster and Glanbrook, which are mainly rural areas. The service provision in those areas is pretty thin, and that's only because the services that are trying to address issues in those areas are underfunded. In addition to improving our information and access situation, we certainly feel we need more resources to cover all of the seniors and other disabled people in our geographic area.

Ms Carter: Thank you for your presentation. I was interested in your idea of federation. I'm wondering in what way it differs radically from what we're doing, because this is a community-driven thing where in each area the relevant agencies are coming together and designing their own plan as to how the MSA will work and how things are going to happen in their area. So I don't see it as a bureaucratic cookie-cutter plan that's imposed from above.

You specified "volunteerism," which is an issue that keeps coming up. I want to point out that there is a joint group with the United Way that is discussing volunteerism, because we want to make absolutely sure that doesn't get lost. I just wonder why volunteers would in fact fall away, because although the agencies will have come closer together and maybe amalgamated, there will be the specific areas of help which is needed. Certainly, Victoria County Community Care, which is an existing group that has brought together a lot of fragmented groups that existed previously, finds that volunteerism is still great.

Also, I just wanted to mention the funding question, because this is a concern that's come up several times. First of all, the whole objective of what we're doing is to have not a sort of bureaucratic planning as to what money goes where over the province, but by dividing the province up into areas that will have their separate funding envelope, we're then handing over to local boards and decision-makers as to how that money will be spent.

I was rather unhappy to see on my local news last night the suggestion that Bill 173 was leading to a reduction in funding and that people were going to have to pay for services in their home that they haven't had to pay for before and so on. I'm afraid that idea of alarm

and despondency is being spread around, but actually the amount of money that's being invested in community-based long-term care is going up very drastically. It was \$550 million in 1991 and \$850 million a little more recently.

The Acting Chair: You've used up all the time that's available. Would you like an answer from them?

Ms Carter: Oh, I'm sorry. Yes, all right.

Ms Walsh: Just some comments on your comments: First of all, I think you have heard from other presentations, better than I could express, what motivates volunteers. Volunteers usually have a very personal reason for doing what they do. True, a lot of volunteers currently involved in services might decide, "Yes, I will continue to be a volunteer in this system called the MSA." However, my personal feeling is that a lot of them will not and that the MSA, because it is kind of a no-name agency at this point, is going to have difficulty recruiting volunteers because there won't be that personal attraction that there has been with some of the local agencies like VON and Red Cross.

On the second point, about the funding, I think a lot of our concern is around the private funding that's raised through agencies through donations and things like that that are now going into service delivery. The money raised by agencies today is going into programs. That will be lost under an MSA. I don't think you're going to get those private donations—that's my personal feeling anyway—at least not to the same degree that you're getting them now for private organizations.

ST ELIZABETH VISITING NURSES' ASSOCIATION

The Acting Chair: The next one is St Elizabeth Visiting Nurses' Association. If the Wellington-Dufferin-Guelph Health Unit show up, they'll be immediately following this presentation.

Mrs Soluk: Good afternoon. My name is Rita Soluk and I'm president of St Elizabeth Visiting Nurses' Association. With me this afternoon are Ms Bernice King, chair of our board of directors, and Mr Hugh Greenwood, vice-chair of the board of directors.

St Elizabeth Visiting Nurses' Association would like to thank the standing committee on social development for the opportunity to respond to Bill 173.

St Elizabeth's is an incorporated not-for-profit agency delivering nursing and homemaking services in the communities of Hamilton-Wentworth and Halton. As well, we provide a volunteer visitor and driver program in Hamilton-Wentworth. Our agency employs approximately 200 full-time and part-time nursing and home-making staff and has approximately 130 volunteers.

We support the principles and goals of long-term care redirection. We support a coordinated and integrated consumer-driven system of care that is delivered by locally based, volunteer-led, not-for-profit agencies.

Our purpose today is to share with you our concerns with the proposed legislation, the Long-Term Care Act.

At the June 3, 1994, district health council workshop, the Honourable Ruth Grier stated that the legislation would "support a coordinated and integrated system of care" and that this care would be "delivered by locally

based and volunteer-led, not-for-profit agencies." In the Honourable Ruth Grier's statement to the Legislature on June 6, 1994, she said the legislation "enables us to create a coordinated and integrated system."

St Elizabeth's is an advocate of these positions. Our joint presentation today with the Victorian Order of Nurses and the Visiting Homemakers Association is evidence of our support for and commitment to a coordinated and integrated system of care being delivered by locally based, volunteer-led, not-for-profit agencies.

Our joint proposal indicates that it is possible and desirable to achieve a system of care without amalgamation. In fact, our proposal supports a truly integrated system. It allows for the principles and goals of long-term care reform to be realized without alienating long-standing allegiances and devotees to specific causes.

However, this legislation requires amalgamation. We see amalgamation to be destructive rather than corrective. We believe amalgamation eliminates consumer choice of service provider. It eliminates community control and decision-making in establishing a system of long-term care services which will best meet the needs of community members. It creates a monopoly which will, over time, demonstrate a number of characteristics common to monopolies. There will be loss of incentive to respond to changing health trends and consumer needs, to be innovative, cost-efficient or provide quality services in a timely manner. Exclusive control of scarce resources by a concentrated authority will erode the more esoteric services and lead to the provision of inflexible, routine services.

1440

We strongly recommend that the requirement for amalgamation be eliminated. We support community determination of a system designed to best meet the needs of its residents.

It is expected that the ministry will develop evaluation criteria against which to measure the success of amalgamation. Instead, we strongly encourage the ministry to develop criteria from which a community can develop a system plan and against which the ministry can measure its plans.

The 20% ceiling eliminates consumer choice, one of the basic principles of long-term care policy. The only exceptions to this ceiling are purchase of service from individuals by MSAs and purchase of service from any provider by consumers who have received grants. In both cases, it will be difficult to monitor the quality of service delivered. It will be difficult to monitor the appropriateness of services purchased by those with grants.

We recommend the 20% ceiling be eliminated. We recommend that local communities determine their purchase service requirements.

We applaud the development of an appeal process. We are concerned that while appeal boards possess the right to rescind and substitute decisions, they bear no responsibility for the costs associated with these decisions or the impact such decisions may have on the community's ability to respond to overall community needs.

Potentially, vocal groups with established networks

could use the appeal process to dictate the allocation of funds and service plans at the local level. Community members who are not members of an established network, such as those requiring acute care services, palliative care services and other transitory services, could potentially fail to have their service requirements met.

The proposed funding formula does not provide for decisions made by the appeal boards.

It is imperative that guidelines be established which limit appeal board powers to functioning within the overall community service plan.

The composition of the appeal board is unclear. We recommend that membership of the appeal board reflect that of other committees proposed in the legislation; that is, "consumer," "provider" and "other" categories.

This legislation does not indicate whether client service will continue while an appeal is in progress. We recommend that this point be clarified, given the potential consequences of such service interruptions to the consumer. While the consumer has recourse through the courts in cases questioning violation of rights, we suggest that this may be too lengthy a process for the consumer as well as having a negative impact on the whole system.

Existing situations contain both union and non-union staff. Both groups, we believe, have rights and deserve equal treatment. Union affiliation should not predispose staff to preferential treatment. The original selection of MSA staff should be based on years of service within existing agencies, not seniority within unions. Staff selection should be based on experience, education and other job-related factors.

The new system will experience considerable costs associated with achieving parity in wages, benefits and changes in pension plans. Staff relationships will become strained as they experience job insecurity, compete for new positions, and are displaced in an evolving system.

In all likelihood, bureaucracies will develop. Bureaucracies usually bring lengthened communication systems. They erode staff loyalty and commitment, reduce staff productivity, and bring management and staff conflict. Bureaucracies cause system and manpower inefficiencies which result in new costs. They often breed staff hostility, animosity and dissatisfaction. Surely the consumer will suffer the consequences of this legislation.

Evolving bureaucracies result in funds being redirected to support administrative positions. The consequence is that existing funds used to support the salaries of staff who provide direct consumer care are eroded. Staff will be forced to join unions or be unemployed. The consumer will lose valuable expertise and knowledge if staff are forced to seek employment in a non-unionized environment.

A number of our programs, such as the volunteer visitor and driver program, could be eliminated. Such programs are financially supported through sources other than the ministry. These funding sources will not guarantee ongoing financial support in light of the proposed legislation.

The costs related to anticipated loss of volunteers are significant. Volunteers are the backbone of many services

which have evolved in response to identified consumer needs. Consumers who value and depend on these services will be the ones to experience the consequence of the loss in service.

The distribution of grants to individuals able to manage their care is supported. The criteria for grant application are not included in the act. We appreciate these are under development right now, but clearly that needs to be defined and we need to understand the approval mechanism. However, what is clear to us is that exclusion of any consumer from this grant process supports the evolution of élitism. The appeal process, as pointed out earlier, allows for potential control of MSAs by established groups or networks with effective lobbying skills and knowledge of how to access the system. Hence, the appeal process brings with it, again, the potential for evolving élitist groups. While it might be argued that the legislation enables all community members to have a voice, it is clear from the low attendance at recent community forums held across the province that the general public have very little, if any, appreciation or understanding of the potential impact of the proposed legislation.

The act makes very little reference to the acute care population, a population which constitutes an equal or greater as well as growing proportion of those receiving long-term care services. Despite this fact, they are not now, nor are they likely to be, members of a network of individuals able to influence the system. In the main, acute care clients will not know about long-term care services until such services are required. There is no existing network for acute care clients. Acute care clients are not members of potentially elite groups.

We have articulated our position that unionized staff should not be given preferential treatment. Under the proposed legislation, most non-unionized staff will not receive recognition for their many years of service. Does this approach not then create an elite staff group? Certainly, staff should compete for vacant positions based on experience and job-related qualifications. Staff should not compete for positions on the basis of union affiliation. This legislation supports the formation of opinions about others based on their membership in groups with assumed characteristics rather than on the merits of the individual. Is this not the essence of discrimination?

We support the takeover option. In addition, we would recommend that the external party responsible for evaluating the agency in question be a mutually agreed upon third party by both the ministry and the agency. This recommendation is based on a common model utilized in a number of forums for resolution of difference.

Finally, the sophisticated computerized infrastructure necessary to support evolving community structures is not available at this point at either the community or the provincial level. The costs of developing and implementing such information systems are astronomical. We recommend that the financial resources required to support the development of a new technology be found outside of the existing funding allocation.

In conclusion, we would like to restate our support for a commitment to an integrated and coordinated—we

would add consumer-driven—system of care which is delivered by locally based, volunteer-led, not-for-profit agencies. We have pointed out a number of potential, but we believe very significant, consequences of Bill 173. We believe amalgamation is not the only answer. We believe communities must be permitted to develop a system of care best suited to the needs of the community.

We are confident that you will give serious consideration to the concerns we have put forward today, and we thank you for this opportunity to respond to the proposed legislation set forth in Bill 173.

This completes our presentation, and we'll be happy to entertain questions.

Mr Jim Wilson: Thank you very much for your presentation. On page 6 you note that "It is expected the ministry will develop evaluation criteria against which to measure the success of amalgamation." In the interest of good government, would it not be up to the government to show us some studies or some rationale or at least some form of justification for their contention that MSAs will indeed save money and be more efficient? If the answer is yes, as I suspect it is, have you, in all the discussions you've attended, heard anything to make you believe the government's claim?

Mrs Soluk: Actually, the answer is yes, and it's supporting what you've heard in the last few days of hearings. No, I've not been able to find anything. I have done a fair amount of reading. In fact, what I've been able to find is that in health care areas that have gone in this direction, they are reversing it. If you look to industry, the same. So I don't know why we wouldn't learn from the experiences of others.

1450

Mr Malkowski: Thank you for your presentation. You were one of many presenters we've heard with the same theme again and again, which is concern about the role of volunteers and the maintenance and the identity, I suppose, of your volunteer corps for fund-raising and those who actually do the on-line work. We've heard that concern time and time again.

Again, we are proposing that recommendations be made that within legislation we spell out where the role of a volunteer coordinator may be placed under an MSA, and also for outreach and for fund-raising; therefore, to preserve some of the traditions, those roles which are now occupying some agencies out there. Would you feel, if we were able to do that, that that could be something you could support, to see a volunteer coordinator and that position therein outlined in the legislation?

Mrs Soluk: I would suggest that maybe you've missed the point. The issue is not a question of whether we might have a volunteer coordinator or a director or whatever. The issue is whether people would wish to volunteer for government-run sorts of activities. I gave you an example this morning of what happened in our local cancer office. I think I suggest to you on a very small scale what you would see happen in the larger amalgamated approach you're suggesting. So I don't believe a position built in that would support a volunteer coordinator or whatever would be the answer.

The Acting Chair: Thank you very much. We appreciate you coming before the committee today.

Mr Malkowski: Can I just clarify? An MSA is not a government bureaucracy. Again, this is going to be coming from the community. These are going to be community people coming from your own community, elected by the community.

The Acting Chair: I thought you had a supplementary question.

Mr Malkowski: This is a supplementary.

The Acting Chair: So the question?

Mr Malkowski: My question is, following this point, it therein being a community-based organization, would it not be appropriate to have a volunteer coordinator? This is not a government bureaucracy. Would you not then support it?

Mrs Soluk: I would suggest to you, on the evidence you've heard in the last few days, that people aren't in agreement or consistent with your thoughts on whether it would be or would not be a community-based organization. The suggestion out there is that it probably won't be; it would be government-run. If you look at what the act says, that's fairly clear. If you draw parallels between this and the ministry in terms of education or any other sorts of things, I think you will see that that's the sort of thing that will evolve.

The Acting Chair: We appreciate you coming before the committee today. If there is anything further you'd like to say to the committee, you're welcome to submit in writing your brief or further comments to the clerk.

Mrs Soluk: Can I make one short comment, since you offered that to others?

The Acting Chair: Yes, you may.

Mrs Soluk: At lunchtime, when I came back, you were listening to a technical interpretation of the act, and nearing the end there was a discussion about the changes in criteria which allow people now to have services without professional services etc. I would like to share with you the fact that that's been the position of the community service providers for a number of years. We felt that was the sort of thing we should have been allowed to do. The legislation did not permit it. I would suggest to you that this sort of legislation was not necessary to make that happen.

The Acting Chair: Thank you very much.

WELLINGTON-DUFFERIN-GUELPH HEALTH UNIT

The Acting Chair: The next presenter is Wellington-Dufferin-Guelph Health Unit. Welcome, Dr Kittle. You have up to 20 minutes for your presentation. The committee has received your written submission. Please begin.

Dr Douglas Kittle: Thank you for giving me the opportunity to speak to you today about this bill. I have a presentation which I will basically read, but I'll digress from it where appropriate at certain spots.

Long-term care services and community support services in Ontario are in need of major reform. To this end, Bill 173 is welcome, and parts I and III aptly reflect the purpose and rights associated with this reform. However, our board, which is a public health unit board,

finds disturbing a significant section of the act which I wish to bring to your attention. I wish to start by giving you some background to this issue.

Health units across Ontario administer 29 of the 38 home care programs, and I'm sure you know that home care will comprise the bulk of health services contained in MSAs under the Long-Term Care Act. Our stewardship of home care has had its rocky history but has emerged with a strong collegial relationship. In our case, we started with a handful of staff sharing space with public health in the mid-1970s. Today our home care program has a \$14-million budget, a staff of 100, and operates from two autonomous sites in Guelph and Orangeville. At any one time, we have about 2,700 patients or clients on the case load who receive a minimum of nursing and/or therapy service.

I want you to reflect for a second. That's the equivalent of 2,700 hospital beds, you might say, run for a program of \$14 million. However, each one of these people has, in order to get on to this program, a medical diagnosis, and along with that medical diagnosis are health care records. These people will be transferred to MSA services. What will happen to health care records, what will happen to physician reporting and what will happen to the role of the physician in looking after and attending to the people who will be involved in the care provided through the MSAs? There is no reflection of this in the act at all.

All therapy services in our establishment are provided by in-house staff. All nursing and homemaker services are provided by community agencies on contract to home care. In our case, the local VON provides most of these services.

In 1989, the then assistant deputy minister, Dr Bob MacMillan, commissioned Price Waterhouse to review home care programs across the province. The report was favourable to the local administrative arrangements except for some of the arrangements where it was felt there may have been conflict of interest by virtue of the fact that the agency that provided the service also was the agency that administered the program. A potential conflict of interest was raised as the issue here. The report identified a number of management shortfalls at the central level, most to do with poor centralized planning. I stress that point: poor centralized planning, not peripheral administration of the services.

Administration costs in our program are less than 10%, and the health unit receives \$40,000 annually to administer the \$14-million budget. Home care does cost-share on payroll and other incidentals, but it is far from a cash cow for this agency.

I think if you were to review voluntary agencies such as Oxfam, you would be hard pressed to find voluntary agencies like this which have administrative costs at 10% or less.

All this said, we are proud of the history and achievements this community-based health service offers. The staff commitment and allegiance to home care must be experienced to be believed.

What I wish to digress on this is the whole issue of

goodwill of staff and volunteers. A lot of what is currently happening out there wouldn't happen if it wasn't for the goodwill of the people who provide the program. This present bill is tampering heavily with that goodwill and I do not see an avenue that will come out of it which will salvage that goodwill. I think the previous speaker spoke to this again with respect to maintaining voluntarism.

With all this in mind, our health unit board and administration are perplexed and even angry at one clause of the new act which disregards our chances to be a governing agency for an MSA. It is as follows, part VI, 11(3): "Before designating a municipality or a board of health as a multiservice agency for a geographic area, the minister shall consider the suitability of all other approved agencies in the geographic area for designation as multiservice agencies."

From the clause, it is clear the health units have been designated a last-place priority with respect to governance. You can see that in the face of no previous problems, a good track record and a favourable review—Price Waterhouse—this is clearly a slap in the face to our record of hard work developed through 20 years of service.

What is interesting here is how this clause appears to also fly in the face of local decision-making. The emphasis stressed by all the multicoloured documents issued in 1993 is that local district health councils are to lead local discussions on how they wish to proceed on the formation of MSAs. The product will then go to the minister for acceptance. In the new legislation, she has determined in advance what local options she will not accept.

1500

The rigidity of the Health Protection and Promotion Act in determining the construct of health unit boards has also been raised as an issue. I believe this is a red herring in that from the onset, ALOHA, our provincial association, has offered the minister an opportunity to discuss amending the legislation to accommodate for MSA governance. This has gone nowhere. It cannot, however, be for the lack of interest in changing existing legislation. Five acts have been slated for amendments to facilitate this bill. The Health Protection and Promotion Act happens to be one of them, changed in this case for the purpose of deleting reference to home care services under the Health Insurance Act.

That is another area which is alarming. I don't know if people here recognize the complexity of some of the cases that are currently on home care services in the province. Programs look after children discharged from hospital early with tracheostomies, very fragile medical conditions. They have patients on the case load who are receiving intravenous anti-cancer drugs, cancer chemotherapy medications, and many more types of complicated conditions leading up to even palliative care concerns. Yet again I reiterate the point: The medical diagnosis and the role of the physician have totally been lost in this legislation.

The creation of new agencies with new boards appears to be the direction this reform is taking. The cost and time associated with this will be astronomical and are clearly a 1970s solution to a 1990s milieu.

In this way, I read in the legislation that we're throwing out the baby with the bathwater. Rather than starting with what we've already got on the ground, agencies with community-based programs that have been operating, some of us, for over 100 years have been totally pushed aside, with the emphasis on what appears to be new boards, new administrations, which spend hours and months and years establishing themselves in communities.

We ask that the playing field be levelled so community options are not compromised and health units are given equal opportunity with others as potential sponsors of MSAs. If this is not to be the case, then health units and municipalities at least should be apprised of why they have been chosen the agency of last resort.

Thank you for your time.

Mrs O'Neill: I presume the Wellington-Dufferin-Guelph Health Unit has been involved to this point in the planning towards an MSA with the district health council. I'd like you to comment on that as well as how you see the Health Protection and Promotion Act changes that are going to be coming with the changes to the Health Insurance Act.

Dr Kittle: The health unit has been involved from the inception of the formation of any of the organizing committees, both in Dufferin county and in the Guelph-Wellington area. We are at the table, myself personally or a representative from the home care program, the director of the home care program.

Let me say that in my 20 years in public service as a community physician, community health specialist, I have yet to come across a piece of legislation that is as woolly and difficult to get around. I will speak frankly. The district health council's planning committee is flummoxed—I believe as flummoxed as I am—on how to proceed with this cumbersome, hard-to-get-into and hard-to-get-around type of legislation. We're at the table but I'm not so sure we're making great progress.

I'm sorry. Your second question was something to do with the insurance act?

Mrs O'Neill: Your third-last paragraph regarding the Health Protection and Promotion Act and the changes to the Health Insurance Act under this act, and how you see that affecting your clients.

Dr Kittle: As I stated earlier, this is de-insuring the home care services. Currently, all services that are provided are insured services and we have to provide them if the patient-client is eligible for the service. Under the new formula there will be a funding envelope, and no matter what comes forward, we will have to take from the envelope and be unable to go beyond that, to the best of my understanding.

My point in that particular paragraph, however, was that the Health Protection and Promotion Act has been used—the rigidity of health unit boards is stated in the health protection act. In other words, the health protection act proscribes how health unit boards should be structured. Some have said that structured rigidity would make us poor governance agencies for multiservice agencies.

My point is that we have attempted to talk this point out with the government through our parent association,

and this has gone nowhere. They have gone into the act to change it in order to de-insure the services, so it's not not wanting to go into the act. That's my point.

Mr Wessenger: Thank you very much for your presentation. I certainly note your concerns about the problems of confidentiality, particularly in the question of absence of consent, and that will be taken note of.

I'd just like to ask you a couple of questions with respect to your concern about why a public health unit could not be an MSA. The first question is, in view of the other major responsibilities that public health units have, how would we ensure that the public health unit would have the focus on long-term care that's absolutely needed? Secondly, what would you recommend with respect to restructuring with respect to public health units in order to ensure that a public health unit had the true consumer input that is really needed in the management of long-term care, that true consumer community input?

Dr Kittle: Those are excellent points. The first is that if you read the act, it is possible to have community membership on the board one less than the municipal membership. In our case, we have members from the city of Guelph, county of Dufferin and the county of Wellington. If they total 10, it is possible, under the current Health Protection and Promotion Act, to have nine community-based members. It's how you choose those members, which is at the discretion of the minister, for appointment. So it is possible even under the current legislation to have good consumer input.

However, we have recognized that there are restrictions with the act and we're very interested in opening dialogue, discussion, with the minister about that. In other words, our parent association, the Association of Local Official Health Agencies, has been willing to look at going into the act, changing it, and restructuring the board structure so that it could reflect some of the parameters required under this legislation for more consumer input.

Mr Wessenger: Fine. Thank you.

Mr Jackson: Doctor, we have not received much input from physicians individually during the course of the early part of the hearings. Could you perhaps help me with an understanding of how you envisage the relationship to physician referrals as they now work and how physician referrals will have similar responsibility and linkages under the new system? Obviously you've been able to put your mind around that, given where you're coming from and where you're currently serving the public.

Dr Kittle: Currently, all clients who are on the program have to have a physician referral. In order for the services to be provided, that physician referral has to be there.

The new approach is to have clients on the program, but there is no comment as to what will happen with the referrals and what is the liaison, networking relationship between the physician who has the patient—the patient is on the program—and the relationship with the program back to the physician. Currently, there is an accountability factor. That accountability factor appears not to be

in place under the new legislation. The concern here is that in our area, if we have 2,700 people currently being serviced on a daily basis, those are the same kinds of people, plus a few others, who will receive the services under the MSA. The style is not going to change, and yet where are the assurances on accountability confidentiality with respect to reporting and records maintenance? I don't see it.

1510

HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL

The Acting Chair: Is the Hamilton-Wentworth District Health Council here? Please come forward. You have up to 20 minutes for your presentation. You've probably heard me say this to others, but please begin by introducing yourselves, and if you'd like to leave a little bit of time for questions, we'd appreciate it.

Ms Barbara Mahaffy: Madam Chairman, honourable members, it is my pleasure and privilege to be present today to submit comments in response to Bill 173, An Act respecting Long-Term Care. I am Barbara Mahaffy and I speak to you today as chair of the long-term care committee of the Hamilton-Wentworth District Health Council. With me is Posie Poushinsky, the long-term care planner with the health council.

Just over two years ago, the ministers of Health and Community and Social Services charged DHCs with the responsibility for planning long-term care services in general, and multiservice agencies in particular, in our communities. The district health council of Hamilton-Wentworth accepted that responsibility and began to develop a long-term care committee that has the mission, the authority and the credibility to consult with the community and to represent the community's wishes and needs in developing appropriate systems for this area.

The process of establishing the committee itself was consultative as we sought advice from the community on both committee structure and terms of reference as well as membership.

Provincial guidelines at the time allowed us to be creative in our membership. It was recognized early on that there were not enough seats around the table to accommodate all the expertise in our community without overwhelming the voice of the consumer or making the committee so large as to be unmanageable, so we created an advisory committee of experts from various areas of long-term care. They have provided us with invaluable input in our discussions to date.

As a committee, we continue to support the development of a multiservice agency system and support the intent of the legislation that provides a basis to establish it. However, we have several areas of concern on the growing restrictions to our community planning and our local vision.

When the Minister of Health first talked of MSAs, we were heartened to hear that within certain guidelines they could be developed to reflect community needs. In Hamilton-Wentworth, we have spent the last four and a half months talking to groups all across our geographical area and asking them what is the best way for them to

access service and how we could design an MSA system to best meet their needs. We now have legislation before us that does generically define an MSA but concludes with an onerous listing of very specific areas in which regulations will be established that cannot help but restrict our flexibility in planning. We encourage you to respect the ability of our community to plan appropriate models and to allow both legislation and regulations that are flexible enough to permit a local flavour to the final product.

In our reading of the act, it appears from sections 12(1) and 13(3)(c) that there will be some flexibility for an MSA to provide services through another MSA. On the other hand, there is some indication through the minister's revocation powers that two MSAs may not be allowed to exist to cover the same geographical area. We have a concern that the legislation may be contradictory in interpretation and may hamper efforts in some communities to develop an ethnospecific MSA where the needs of a significant ethnocultural population can only be met in this way.

Another area in which flexibility of planning for our community has been limited by the legislation is the area of mandated services. We recognize in these times that there are not always resources to support all the goals we wish to achieve. We urge you to look at the mandated services and consider whether the government will be able to provide the funds to support all the services in all the communities.

We ask that you consider establishing a smaller core of required services that are essential to sustain independence and allow each community to decide which additional services are most essential to meet the needs of their particular community. When resources are limited, it would seem better to do fewer things well than to be all things to all people poorly. Moreover, when we promise a comprehensive list of services and then are unable to deliver them in sufficient quantity, we may leave people at risk in their homes, with services that are too limited to maintain safe independence.

We strongly support a bill of rights for clients and ask you to consider two adjustments to the process. The first is to make the bill of rights a collaborative contract between client and service provider. Allow the bill of rights to be written by the consumers and providers in each community and legislate only the areas of rights to be included, such as access equity, dignity, information and confidentiality. This allows an atmosphere of cooperation and supports the mission and philosophy of most service providers rather than setting up an environment where one needs protection from service providers.

The legislation needs also to protect the valued role of the volunteer in both service delivery and resource generation.

The final group needing protection and recognition in legislation includes those whose jobs are at risk through development of MSAs. Help us to work at ensuring that the rights of all employees, both union and non-union, both management and front-line worker, are respected, and that equal opportunities are available in work reallocation.

We support the appeal process and encourage that it be used to strengthen the bill of rights by allowing clients to take a denial of their rights to the appeal process. The appeal process also needs to respect continuity of service to the client and ensure that service is not disrupted while the appeal is ongoing.

We ask also that you support our need for time to do our planning work well. As a standing committee, you appreciate the time needed to consult effectively with the community. Our planning has not occurred in a vacuum, and consulting with our community takes time as well. We are committed that our community's input will impact on our decisions and will not be in name only. The four-year time frame for fully developed MSAs is restrictive, and we feel it will not allow sufficient time to try and test a model, to work out collaborative or amalgamated systems, to manage employment relationships and to resolve court challenges and succession issues.

An overriding principle of long-term care reform has been the integration of health and social services to provide consumers with a coordinated, comprehensive long-term care service continuum. The policy framework of April 1993 supported this principle in the partnership among the ministers of Health, Community and Social Services and Citizenship and their respective ministries.

Our community, throughout our consultation process, has expressed concern that long-term care service system reform is in danger of being based on a medical model where consumers are viewed as "sick." In an attempt to strengthen linkages between health and social services, our community requested that our local process ensure balanced health and social service involvement on the long-term care committee, in local consultations, and in all activities associated with long-term care planning. We request that Bill 173 be amended to reflect the partnerships, roles and responsibilities which exist between the ministers of Health and Community and Social Services and their respective ministries.

1520

In summary, we request that the legislation (1) build more flexibility for local perspectives on MSA structure; (2) indicate a commitment to local community-based planning and development of the MSA, and (3) indicate a commitment to establishing an MSA which has the capacity to govern as an autonomous organization with responsibility for program planning and service delivery according to consumers' needs and local circumstances.

The document distributed more specifically defines our recommendations. We, like you, are committed to achieving a system which is consumer-focused and tailored to the unique needs and characteristics of communities across Ontario.

The Acting Chair: Thank you very much for a very comprehensive presentation. I was listening. We do have time for a couple of questions.

Mr O'Connor: Thank you for your presentation. I was just noting—and then I tried to follow up in your other document, and didn't realize that you had this appended to it. I like what you've suggested here with the bill of rights and the appeal process, and in fact one

of my colleagues has brought this up a couple of times. In making the bill of rights something that's appealable, it gives it then some more strength, and I wondered if you might have anything that you'd like to add to that, because I think first of all we want to make sure that this is something that's taking care of the needs of the consumer, and so the appeal process is going to be important. We don't want to make it too cumbersome for the consumer yet serve the needs of the consumer.

Ms Mahaffy: I think it's important, when we're looking at the bill of rights, that the consumer has some input into the bill of rights so that both the consumer and the provider have ownership of the bill of rights. Then they become partners in ensuring that the bill of rights is maintained within the service delivery system. Given that, then when a consumer feels that their rights haven't been maintained and it's based on a contract with a provider, there's an opportunity to take it to the appeal process and to appeal that provision of service which hasn't fulfilled the bill of rights.

Mrs O'Neill: I believe you're the first district health council that has come formally before us, although we've had contact with others. I'd like to ask you to say a little bit more about the difficulties you've having with the terminology "geographical area" and how that relates to the guarantees within the bill and the guarantees that no doubt have been put before us over and over again in long-term care reform about guaranteeing cultural and spiritual values and, in some cases, the disease-oriented focus as well. So could you tell us a little bit about the struggles you're having with trying to balance those two phases of the bill?

Ms Mahaffy: I'm not sure that the geographical issue is a particular concern in the Hamilton area. With respect to cultural issues, one of the difficulties that we're having which I'm sure is a difficulty in many communities is the urban-rural mix as well as cultural differences within our community.

The variations in culture tend to be within the Hamilton core, but there's a great deal of difference between the Hamilton core and the rural areas which we also are planning services for. The rural areas tend to have fewer services presently and we have enormous difficulties with transportation to either get services to them or to get them to services. So it's more a rural-urban geographical issue that Hamilton has. The cultural issue is certainly large in Hamilton, but it's one that isn't a geographical issue.

Mrs O'Neill: Do you foresee more than one MSA for Hamilton-Wentworth?

Ms Mahaffy: Yes, although we haven't decided on a model that we're going to carry to the community yet. We're still looking at a number of different options, but I think it certainly will involve more than one MSA.

Mrs O'Neill: Thank you.

The Acting Chair: Thank you very much for coming to the committee today.

Is Mr Farnham here yet, Care Plus?

In that case, I'll call St Joseph's Villa. Please come forward.

RESPIRON-CARE PLUS

The Acting Chair: Is that Care Plus that has just come in the door? In that case, thank you for being so understanding. Please come forward, Mr Farnham. The clerk will distribute copies of your written brief. If you'd like to just sit down, speak right into the microphone—either one, it doesn't matter; Hansard will turn on the one in front of you. There we go. If you'd just give us your name, relax and you've got up to 20 minutes for your presentation.

Mr George Farnham: That's a little difficult. I'm just walking in—I'm a little bit early.

My name is George Farnham. I'm from a local company called Care Plus. I'm also an active member in the OHHCPA, which is the Ontario Home Health Care Providers' Association.

Thanks very much to the committee for allowing me to speak today. If I can speak for a little bit of preamble, some of what I have to say today I'm sure you've heard from other representatives of our association. However, what I'd like to do is perhaps put a little bit of a local flavour on what my company and the other agencies in Hamilton feel about this Long-Term Care Act.

I have about a 10-page written proposal here. And I'll try to keep it as brief as possible. I'll read through it. Seeing as it's double-spaced and quadruple-spaced and so forth, I'm sure that this shouldn't take too long.

As you're probably already aware, our association represents 115 offices across the province of Ontario. We provide substantial government-funded home care annually to the various people who require it, being seniors, disabled etc. We employ approximately 20,000 people through our agencies.

Some of the figures that have been shown in texts that I've read say that our agencies represent about 40% of the publicly funded homemaking hours. However, in this community it actually represents in surplus of 50%, and has for the last several years.

What I would like to say today is that unlike some of the other communities in Ontario which are genuinely in favour of restructuring the whole system, I believe in our community, in Hamilton-Wentworth, the present system that has been in place has worked very, very well. All the agencies, including the not-for-profits, the home care program, have worked extremely well together in the areas of trying to increase quality, provide flexibility as well as cut costs. In the past, we've worked together and we've done an excellent job I believe in meeting those needs.

We believe, certainly in this community, that a multi-service agency will not save us, as taxpayers, any money. And in fact, we believe that all it will do is create less responsive approaches to the needs of the community.

Some of the issues that we want to bring forth are issues that I'm sure you've heard before. However, we think that this legislation will hurt not only the clients who require home care but the workers as well in both the profit and non-profit agencies, and, last but not least, businesses in Ontario.

The government's policy to restrict our agencies to

10% most assuredly would put my business out of business.

Apparently there's been a change in the original proposal from a 90-10 proposition, that being 10% limitation as far as commercial agencies were concerned, to a 20% portion of the business. Even at this rate, this will cripple and certainly put a good many of the commercial agencies out of business. Some of these businesses are founded and run by Ontario people, largely a female population, entrepreneurs, and a lot of effort and time has been put into putting together a good solid business that serves the communities.

1530

The MSA, as was stated by the Minister of Health, is supposed to provide one-stop shopping for Ontario consumers. However, that's in fact what it does. It only provides one place to shop, and we feel that we've taken away not only the competition that should be in place, but also the consumer's choice. A good example would be that if the MSA does not meet someone's needs, no matter what those needs might be, the consumer will not have anywhere else to go if there will only be one choice.

People who are unhappy and would like to voice their dissatisfaction, the majority of these people, I think, are in a vulnerable position in that they're going to have to take their issues to the same people that provide the service, and we feel that in fact they may be fearful to represent themselves because their service may be taken away. I'm sure at other presentations you've been given all the data about this very same or a similar format that's been provided in other areas, Great Britain, Sweden and even in our own country in Manitoba, where this model has been rejected and in fact in many places has been replaced by the type of system that has been in place.

Our recommendation, obviously, is that Bill 173 be amended and that section 13 be taken out in its entirety. From an employer's standpoint, we've invested a great deal of time and effort in training, creating a good working environment, lots of support as far as supervision is concerned, and it's our feeling, based on what we've been told, that a lot of the new jobs created in MSA will be filled by laid-off workers from hospitals, and that our employees who may be seeking other employment will not have a place. Therefore, I think that we're going to lose not only the experience but their expertise, and in that vein we believe the consumer will then suffer.

We also agree that a more coordinated information system would also be beneficial, as long as the local people would operate this system on a daily basis and that it is not in fact dictated or run by the provincial government. In section 12 of the legislation, we talk about what the MSAs will do, what services they'll provide. There'll also be funding restrictions and possible waiting lists, and we think that in addition to some of the services that will be provided, there may be others and in fact this bill does not allow the local people to make those approvals.

Again, as you're probably aware, in other communities around Ontario, administrators in the home care realm are

challenging this particular piece of legislation, and are denying the government and saying that, "We're not going to implement this because this is not in our best interest or for the community." The examples, of course, are Ottawa-Carleton, Hastings, Prince Edward, Kingston, and Haliburton-Kawartha. They believe that the non-competitive policy will hurt not only the consumers but their community.

We'd like to see the government provide the local authorities as much freedom as possible, develop some policies perhaps, set out some guidelines for realistic services, provide financial resources, and then make those moneys available to the local community so they can determine the priorities for their community.

It's also our belief, particularly in the Hamilton-Wentworth community, that there is a major restructuring being done here to a program that essentially met the basic needs and was very workable for all involved, including the consumers and the companies like ours, and we're very frustrated with the fact that a massive change is being proposed as opposed to perhaps working with what we have and making a minimum change and less interruption in the system.

I alluded to earlier that, in the Hamilton-Wentworth area, the private sector has contributed to the success of the home care program here and in fact provided in surplus of 50% of the business, and I think that speaks well for our companies. One of the reasons why we have increased our volume to that level is that we were more responsive to the needs of the community: working 24 hours a day, seven days a week, giving clients what they needed as opposed to what they were told they could have.

As far as the funding issues are concerned, we receive the same dollars for funding as any of the non-profit agencies do. As you're well aware—at least, I haven't seen any studies that say that in fact the quality of care or the value of the services provided by commercial agencies is any different than that of the not-for-profit, and therefore we believe that we should not be taken out of the system.

The minister has also stated that funds should go into care, not for profit, and again there's been no research or no studies to show that the not-for-profit agencies provide more or better care than we do.

The client issue is a very close one as far as I'm concerned, because we establish with our clients a good rapport with the people who look after them on a daily basis. We feel that any change in this policy or an MSA will most certainly disrupt provision of care to these people. One of the points that provide for a better relationship and an ongoing wellness program is consistency. So we feel that removing our worker or perhaps upsetting the situation in anyone's home will be detrimental to our clients.

I'd like to mention that I'm a very active member of the OHHCPA and certainly share their views and have been involved in some of the changes that we would like to propose. I know you've heard these before, but I'd like to read one more time what our proposal would be, or the following initiatives that we'd like to propose:

(1) We feel that the government should determine what services it can afford to provide and then fund those services in an equitable and consistent fashion across the province.

(2) Local communities should ensure that services are provided as efficiently and effectively as possible through managed competition.

(3) Consumers should have more choice in the services they receive as individuals rather than having to fit into a specific program.

(4) The development of a client-focused information system which coordinates community and facility care must be a priority.

(5) The government must give local communities responsibility to allocate resources at the local level in response to local needs, and the Ministry of Health must stop trying to manage the operations of the home care program on a daily basis.

1540

In conclusion, I would like to assure the panel that in all cases, both profit and not-for-profit agencies, we're here to meet the needs of the consumer. However, we do want to maintain the essential qualities of the current system, which again are competition, consumer choice and a program that fits the community. It's my belief that Bill 173 in its current form will remove all the positive qualities of the present system, and ultimately, home care consumers will have fewer services and less choice.

Mr Jim Wilson: Thank you very much for your presentation. It's no secret, we've been saying it all week, that I and my caucus colleagues will certainly move an amendment and hope that the government supports it on this committee to delete any reference to the 80-20 split. We think it's a ridiculous, arbitrary game that the government has decided to play. You're absolutely right in your presentation; there are just no studies to back up any of this.

I'd like to know, though, because you talk about the crippling effect this will have on all agencies and it will have an effect on your business, how many employees will be affected in your company alone.

Mr Farnham: From the standpoint of homemaking, it would be in the vicinity of 250 employees, as well as administrative people, who represent probably another 10. So I'd say about 260 employees.

Mr Jim Wilson: Thank you. Could I just mention for the record that you mentioned that the private sector is providing about 50% of homemaking in this part of the province. Just for the record, the provincial average is just under 50% across the province. So you're an important player in the system and the government shouldn't be trying to put you out of business.

Mrs Sullivan: I also wanted to ask about the 10%, 20% rule. There's been evidence before our committee that while the government's first policy was that only 10% of services would be allowed to be purchased from commercial operations, indeed the 20% that's included in the bill isn't a matter of only the for-profit services that can be purchased but relates to any and all services that can be purchased outside of an MSA. That 20% then

would include anything that an existing agency now provides; in other words, 80% of services that would be taken away and put into the MSA.

The 20% would not provide a critical mass of service needs, and therefore virtually all of the existing agencies would fold without compensation. Now, that compensation issue is one that was addressed earlier with respect to severance for workers in non-profit agencies. I wonder if you would address the same issue with respect to the commercial sector; severance, the benefit plans, pension plans, as well as capital costs. Have you had any promises or any assurances from government that you would be compensated for the loss of your business?

Mr Farnham: Well, no. Absolutely no promise at all from government. In fact, if I may elaborate a little bit on this, obviously we offer nursing services as well which are not government-funded, and our research shows that a full 80% of the palliative care that we do in this community is originally derived from home care, home-making services, and in fact this fallacy that that private business will still be there does not exist. So we haven't been given any assurances.

The Acting Chair: Thank you. Ms Carter, very short.

Ms Carter: I have several points I wanted to raise—

The Acting Chair: Maybe can you wait until the next—

Ms Carter: —but I'll stick to one. You get the same allocation of public funding for the unit of service that you deliver as a non-profit agency does, and, as I believe you mentioned, the minister has raised the question of, where does your profit come from out of that? Does it come from the service delivered, does it come from the wages of the people you employ? I would like to ask an expert opinion as to whether there is any distinction between the earnings of people employed by not-for-profit agencies and for-profit agencies in the delivery of long-term care.

Mr Wessenger: The question raised is did we have any information on the earnings of people between the non-profit as distinct from the for-profit sector.

Mr Quirt: Specifically related to homemaking, you're quite right that the amount paid by home care programs to for-profit or not-for-profit groups is the same. There are 38 different rates, I believe, that apply in each of the home care areas. It is my understanding that on average, and I would not want to mislead the committee so I would like to confirm this with my staff, the wages generally paid to commercial homemakers are marginally lower than the wages paid to not-for-profit homemakers. I will ask my staff to confirm that that's the case. If that's an inaccurate statement, then I'll certainly inform the committee tomorrow—or, I'm sorry, on Monday when we reconvene.

ST JOSEPH'S VILLA

The Acting Chair: I call St Joseph's Villa, who've been very patient. Please come forward. Begin your presentation by introducing yourselves, and you have up to 20 minutes.

Mr Paul O'Krafka: Madam Chairman, members of the committee, good afternoon. My name is Paul

O'Kafka, and with me today is Margaret Lambert. We're here representing the board of trustees of St Joseph's Villa, the board of the SJV senior centre and the St Joseph's Villa and Rotary Club of Dundas respite care program. Mrs Lambert is the director at St Joseph's responsible for our major community support program, the SJV senior centre. I am the executive director of St Joseph's Villa.

We appreciate the opportunity to appear before the standing committee this afternoon. We're especially pleased that you've made the effort to come all the way to Hamilton-Wentworth. We at St Joseph's have been encouraging successive ministers of the province who have had the responsibility for long-term care to visit our facility and services since 1988. While we realize the minister is unable to be with you today, we are pleased that at least one of the previous ministers has arrived in our community.

We do not have a handout for you today that details our presentation to the standing committee. We will be providing a complete written submission once it's been reviewed by all members of our volunteer board, our residents' council, CUPE Local 1404 and other interested consumers of our service. What we have provided for your information are the key documents that guide all our services and programs at St Joseph's Villa. Those documents are our mission statement, our role statement and our management and organizational philosophies. We believe these documents outline the difference that we as Catholic service providers bring to service for seniors in our community.

The major purpose of our presentation is to encourage you, as the standing committee, to rethink and rewrite the legislation which has been introduced. We want to encourage you to allow an adequate opportunity for full consumer and community input into this essential piece of legislation.

St Joseph's Villa provides services to seniors through the SJV senior centre, respite care and supportive care programs, community outreach services and through our 370-bed home for the aged.

The SJV senior centre meets the needs of 173 seniors through a six-day-per-week program. This important service provides nutrition, recreation, therapy, spiritual and social stimulation to the participants, as well as much-needed respite relief to family members, who in most cases are the primary care givers for our participants.

Two years ago our program was serving approximately 20 people per day. In 1994 five of our six program days are fully occupied at 35 people per day, with growing waiting lists, over a 60% increase. Despite this increased demand for service, provincial, regional, municipal and United Way dollars continue to be reduced for this important program.

1550

The St Joseph's Villa respite care program has been in existence as an experimental project since mid-1990. It has been developed through the assistance of the long-term care division of the Ministry of Health, community donations through the Rotary Club of Dundas and

extensive volunteer efforts. Respite care has been available to the citizens of Hamilton-Wentworth because our volunteer board of trustees is committed through the villa's mission to responding to current and future unmet needs of seniors in our community. This program served 103 seniors in this past year. During that same time we had to turn away an additional 97 seniors who came to our door after our beds were already full.

Despite the commitment of the community, the demand for service and an excellent service having been provided, respite care has become a casualty of a long-term care system which is overly committed to planning, legislating and regulating and has lost the ability to be responsive to the needs of seniors. The St Joseph's Villa-Rotary Club of Dundas respite care program falls between the massive crack left by the creation of Bill 101 and the new Bill 173.

This is one of the reasons we wish to address your committee today. It is our hope that before you pass a significantly amended Bill 173 you will consider putting in place safeguards to ensure that current successful and consumer-responsive services are not lost to those seniors and their families who rely on them.

Bill 173 in its current format appears destined to destroy many valued and needed programs and services before rebuilding a new basket of services through the MSA process.

We commend the government on its desire to create a full and appropriate array of services for seniors. We would, however, strongly urge you to consider the limited remaining time available to many of the seniors who rely on services today. The three- to five- to seven-year planning time frame that it will take to put in place a fully working system will extend beyond the remaining lifetimes of many existing seniors. Please do not forget today's seniors as you pass legislation that plans for the seniors of the future.

As a component of our respite care program, the villa has been successful in conjunction with St. Joseph's Hospital in Hamilton in providing supportive care to seniors who no longer require the expensive services of an acute care hospital bed. These patients simply require a period of convalescence before being able to safely return to their own home. Our program has saved the province hundreds of thousands of dollars. It has been able to demonstrate the benefits of community collaboration between the acute care sector, the long-term care sector, placement coordination service and home care.

Having proved the need and our ability to meet this need, we approached the province for support. The only response available from the province through Bill 101 and its regulations and Bill 173 as it has been introduced is to displace long-term residents in order to provide funding and service for those seniors who wish to return to the community. We raise this example simply to highlight the fact that although extensive planning and consultation has gone into the existing long-term care act, Bill 101, when it comes to being responsive to the needs and care requirements of seniors, the flexibility still does not exist.

In addition to advising you of the threats to some

existing services, we at St Joseph's Villa have a significant interest in the future. We have developed our strategic plan with input from the community, input from our volunteer board members and with significant input from seniors and their families. Coming from our 1989 strategic plan, we submitted three new programs to the long-term care division of the Ministry of Health.

Seniors and their families told us they could not get very basic health care assistance in their homes at night. Families of the victims of Alzheimer's disease told us they need a special day program for their loved ones. Senior participants and families in our SJV day centre told us they needed more relief than we could currently provide with our existing program.

In 1990 we responded. We submitted proposals on the appropriate forms to the appropriate ministries. Each year since that time we've been advised that no new funding was coming for seniors and their families in the Hamilton-Wentworth area because new community planning would take place after the new legislation was introduced.

Much collaborative planning has already taken place. It's crucial, as you look at this new legislation, that those efforts in our community not be lost. When we look at eliminating waste and inefficiency, the best ideas for services to this community are already before the long-term care division. Let's utilize some of the work that's already been done in this community.

We commend the province for recognizing some of the efficiencies and economies of scale that can be created through collaboration among a number of community agencies. In our own organization, we collaborate extensively with other community agencies in the planning and delivery of services we provide.

Most importantly, we have been able to successfully do this while maintaining our own mission and governance structure, which we consider to be the most essential component driving the services we deliver to this community and have delivered over the last 115 years.

Since 1985, in addition to collaborating with other community agencies, we've worked very closely with other member facilities and services that currently create the St Joseph's Health Care System of Hamilton. You heard earlier this morning from Sister Joan O'Sullivan on behalf of the health care system and I would simply reiterate that we have already taken those steps to ensure that all available dollars are used to provide services to seniors. We would hope once again that Bill 173 could build on the strengths already developed in organizations like St Joseph's Health Care System.

If there is an urgency to pass this legislation, it is because it has been used as an excuse by the current and previous governments to delay taking any significant action in response to consumer and community needs in the long-term care area.

Mrs Lambert will now cover some of the specific areas where we feel this legislation, if it is to go forward, needs to be amended.

Mrs Margaret Lambert: The areas I would like to focus on are as follows:

The provision in the legislation for MSAs to purchase only 20% of their services from private agencies, including existing non-profit agencies: The SJV day centre would have to be absorbed by the MSA if it is to receive funding. This would pose a great problem in that the commitment of our staff and volunteers and the many non-government dollars that we currently contribute would be lost. This would probably result in the community losing a valuable service that is currently available and serving 173 seniors.

We appreciate Mr Quirt's comments from this morning when he advised the standing committee that you, as a committee, could choose to recommend revisions to Bill 173 which would exempt seniors' centres which are part of a facility-based continuum from the 20% rule and provide sufficient funding outside the MSA system to ensure continued services to seniors. We would strongly encourage you to make this amendment.

Secondly, the ministry's role in ensuring quality management, and I quote from the act, "An approved agency shall ensure that a quality management system is developed and implemented for monitoring, evaluating and improving the quality of community services provided or arranged by the agency": In our experience, the development of an extensive quality management program has taken over eight years. The program was developed with major input from consumers, volunteers, the governing body and staff. We certainly feel that this is not a ministry role and would be looked at as micro-management on the part of the ministry. The time just would not be available for such an in-depth program.

Thirdly, funding of new services under Bill 173: It is important to recognize that many existing services to be absorbed by the MSA are already being underfunded. The SJV senior centre had to cut an activities-of-daily-living position due to the fact that the budgets have been reduced. This has forced us to provide less service for our senior centre members such as bathing and nail care. Bill 173 states that services provided by the MSA would not be charged to the seniors using the service. Presently, seniors, if they can afford it, are paying for most of these services. It would be important to not stop the charges until all the funding is in place. This will ensure the system will have enough dollars to cover the cost without more cuts. It is important that we do not repeat the underfunding which is being experienced by long-term care facilities under Bill 101.

1600

Fourthly, the artificial barrier created between acute care hospitals, long-term care facilities and community support services for seniors under Bill 173: We are very concerned that the approach being taken serves to isolate long-term care from other aspects of the ongoing reform of the health care system in Ontario, particularly hospital restructuring and the long-term care facility redirection. Although the current reform process talks of integration, it encourages isolation. It does not encourage the development of a true continuum of care.

Bill 173 is committed to the important principle of reducing reliance on facilities and strengthening care in the community. We support this principle. We believe the

preferred place for care is in the home; however, we recognize that this goal is not always an achievable one for every individual for a variety of reasons including the inadequacy of support services in some communities. The facility-based system of care and the community-based system of care should not be isolated from one another. There's a clear need for equitable treatment of facilities and community services in the reformed system in terms of standards, funding and accountability and levels of care.

Fifthly, the bill of rights, as included in the legislation: St Joseph's Villa has a bill of rights and responsibilities for our residents and community outreach clients that was developed collaboratively with residents-clients and the villa. The bill of rights and responsibilities strongly reflects the mission and values of our organization and, at the same time, addresses such issues as equity, dignity, information and confidentiality. The legislation should not have to provide a bill of rights but only ensure that one exists and meets certain criteria.

Finally, consumer choice: Under the current system the public has a choice in the services that they receive and from whom. Under the new system there may be one-stop shopping, but consumers are not aware that criteria will be put in place which will actually limit their access. There will also be no choice of agencies to provide services as they will not exist if the MSAs are established as currently outlined.

In closing, I would like to emphasize five points:

The board of trustees of St Joseph's Villa supports the goals of the long-term care redirection and the goals stated in the development of this legislation. Our disagreement is with the method of proceeding with the reform as put forward in Bill 173.

We support a full array of services being available to seniors in all areas of the province. We support these services being provided by a diverse array of volunteer agencies who come from and are part of the community they serve.

We do not support or encourage the creation of yet another large government bureaucracy which we believe will discourage volunteerism, will not be responsive to consumer needs and wants and will be significantly hampered by lack of available government funding.

We believe that the consultations to date on long-term care have indeed been extensive, but we believe those consultations have missed the target.

We believe that seniors and their families need to be part of the consultation on long-term care redirection and Bill 173. We do not believe that the seniors you have heard from to date are representative of the seniors needing services in the province of Ontario.

The Acting Chair: Thank you very much for coming to the committee today. We appreciate your presentation, your warm welcome and your patience.

ALZHEIMER SOCIETY FOR HALTON-WENTWORTH

The Acting Chair: The next presentation is from the Alzheimer Society for Halton-Wentworth. Welcome. We'd appreciate it if you'd start your presentation by introducing yourselves to the committee.

Ms Gertrude Cetinski: The Alzheimer Society for Halton-Wentworth really appreciates the opportunity to present its position with regard to Bill 173 to this committee.

My name is Gertrude Cetinski. I'm the education director for the society, and with me today is Dr Jim Galloway. He's a board member of our society and a long-standing member of our community involved in the delivery, management and planning of health services.

This is a verbal presentation, but we will follow up the presentation with a written submission that will elaborate our point of view and also will make some specific recommendations as to—

The Acting Chair: What you're saying is being recorded by Hansard, so you shouldn't feel an obligation that you must submit something in writing. If you want to, that's fine, but everything you say becomes part of the official record.

Ms Cetinski: We want to.

The Acting Chair: Okay.

Ms Cetinski: We share the concerns and the views expressed by the joint presentations of the St Elizabeth Visiting Nurses, the Victorian Order of Nurses and the Visiting Homemakers Association earlier in the day; also, the submission by the Coalition of Community Health and Social Service Agencies of Hamilton-Wentworth, of which we are one of those 21 members; also, presentations by the VON in Halton and some of the other communities. We will not repeat them, not at this stage in the proceedings. Rather, we want to, in this short presentation, focus on two of the issues that we see around the MSAs in the current legislation that concern us the most.

The first one is, we feel there's a need to protect special services for cognitively impaired individuals and their care givers, and second, we want to draw your attention to some of the real costs that we see to our community when we lose voluntary agencies such as the Alzheimer Society under a fully amalgamated MSA.

Let me briefly tell you who we are. The Alzheimer Society for Halton-Wentworth was incorporated by volunteers in 1982 to serve both Hamilton-Wentworth and the Halton region. In 1987, the society received funding at the rate of 70% through the Ministry of Community and Social Services, Hamilton area office, to provide counselling and family support services to families affected by Alzheimer's disease and related disorders. We hired our first full-time staff person and opened our resource centre in Hamilton. By 1994, the society had grown to employ four full-time and five part-time staff people who in 1993 made over 10,000 contacts with clients with families in the community.

In 1991, after serving Halton as well as Hamilton with donor funding to make up what we received from the ministry, the society finally obtained operating funding for Halton through the Mississauga area office of long-term care, and with the help of the community, a satellite resource centre was established in Burlington. This gave the society a presence in the community in Halton and facilitated access to our services for Halton clients. In

addition, however, our location in the rotary health care centre side by side with Red Cross homemaking and the seniors' help line enabled us to collaborate effectively with other agencies providing services used by our clients. The sharing of common facilities and resources has proven to be cost-effective but also to provide better service to our common clientele.

Now let me tell you about our concerns with the proposed MSA legislation. I would have liked to have a family member alongside with me to share with you the challenges of living with and caring for a loved one who's gradually losing short-term and long-term memory, the ability to think and reason and, over time, will lose the basic skills to look after themselves on a daily basis that we take for granted.

1610

However, care givers find it very difficult to break away from the task of 24-hour supervision and from a job that is both physically and emotionally taxing. You will hear from some of our care givers by letter as to what their needs are and the way they feel the legislation does not address those needs. We've helped our care givers become familiar with the legislation, which does not take away from the burden of care provision which is their primary focus.

So based on our experience with care givers, let me speak on behalf of 4,700 persons with dementia within our chapter area and their family care givers who are providing 90% of community care. Alzheimer's disease is the most common type of dementia and it affects about 5% to 10% of people over age 65, but it can occur earlier. The disease can last from two to 20 years and it is always fatal. There is no known cause or cure. Statistics indicate that by the year 2000, the number of people affected by the disease in our region will double.

The disability of the mind created by dementia is cognitive impairment, which results in a dependence on others to carry on the simplest tasks of daily living. In addition to help from general health professional and support services, persons with cognitive impairment require special approaches to care to affirm their personhood as they and their families live with this disease. The needs of their care givers are closely linked to the highly individual, changing manifestations of the disease in their relative.

The Alzheimer Society both at the chapter and the provincial levels is concerned that specialty services for those with cognitive impairment and their family care givers are not addressed specifically within the proposed legislation which will, however, affect the care provided to the ever-increasing number of persons with dementia in our aging society.

We fear that the funding of dementia-specific programs such as those provided by our society, by day programs and in-home respite programs may be lost to a more generic, general type of programming under the MSA. Those of us who work with the cognitively impaired and their families are convinced that generic programs are inappropriate for those suffering from dementia. We have been working for years to achieve the level of dementia-specific programming now available in our community.

In part II, sections 3 to 7 of the proposed legislation, there's a categorization of the types of services that MSAs will be mandated to provide. It seems that our clients' needs will have to be met by providers in any or all of those generic service categories without any assurance of continuity of care, the special training of those providers and timely availability of specialty programs.

For example, the finite list of homemaking services includes ironing, mending and menu planning but does not specify behaviour management, which is germane to any care and to any of those tasks delivered by the homemaker, or specify sensory stimulation of cognitively impaired individuals.

What we mean by that are planned activities that build on the remaining abilities and enhance life, prevent unsafe behaviours or help in managing those behaviours. Homemakers and support workers are essential in providing those services and special training is essential to help them do that.

We therefore recommend at least that part II, sections 3 to 7, be amended to add a category called "Services for persons with dementia." In our opinion, it would even be better if detailed specifications of the services were dealt with in the regulations to the legislation to allow some open-endedness and flexibility and some rethinking of service categories and the range of services to include specialty programs that presently exist and that are very beneficial to those participants.

Respite is another key service that is not listed as a service category but rather is assumed to be a side benefit to the services of the listed programs. But respite cannot be relegated to the sidelines. It is absolutely crucial to families attempting to continue to care for their loved ones at home and so prevent premature placement in long-term care facilities.

The Alzheimer Society for Halton-Wentworth has just received a federal New Horizon grant to survey the respite needs of families caring for a person with dementia in the Halton region and also the adequacy of existing respite services in that Halton region.

The study will also explore the feasibility of a model of an Alzheimer's respite care centre that we have developed that would provide a home-like, enabling environment and provide continuity of care through a full range of respite services.

Contrary to what you may read in the *Globe and Mail* that states that in the United States dementia services are the third most costly service category, we seriously question those results of the survey. You have to think that not only the people receiving the respite care are benefiting from it; their care givers, at least one, the primary care giver, but many times the whole family, benefits from those services. The cost allocations, figuring it out, have not considered that.

In fact, models now exist throughout the world that have generally proven—these are specific Alzheimer-type models—to be not only more satisfactory care but also more cost-effective. We would be glad to share those with the ministry and also with the district health councils, and we also plan to share the results of the Halton

survey with regard to respite care needs with the ministry and the district health council.

In the meanwhile, we're concerned that the establishment of MSAs will not allow the necessary flexibility to establish the service mix and the funding to operate the type of respite care centre that we envision.

What about our future in the MSA? In both Halton and Hamilton-Wentworth, our experience confirms that collaboration among providers serving the same clientele allows us to deliver service that is integrated at the client level. We support the principles of the reform of the long-term care system and the concept of service delivery through MSAs and we want to participate. Our vision would provide for further sharing among agencies in the areas of administration, human resources, data and records, education and training. We certainly, I want to emphasize that again, support a fully integrated service system.

However, we believe that there will be a real cost to the community if existing volunteer organizations do not retain a place in the long-term care system. Our chapter has a mission to alleviate the personal and social consequences of Alzheimer's disease and related disorders in the regions of Halton and Hamilton-Wentworth. Our funded services presently include, and these would be the services that would be going to the MSA:

- Personal and family information and counselling.
- A library of publications, videotapes and sensory stimulation materials.
- Regular information series for family care givers.
- Drop-in groups for spouses and other support groups.
- Wandering patient registries that we operate together with the police forces in both regions.
- A loan program of in-home wander alert systems that are very helpful to families, and are totally innovative. We developed those systems. We did the research and development on that.
- And our latest program, started at a time when there are absolutely no extra dollars available; we call it Special Steps. We operate it with the VON in both areas, and it provides a volunteer visiting program for cognitively impaired individuals.

1620

But in addition to services to families, those that would move into the MSA into the basket of service, we also provide information and education to professionals, students and care workers in community agencies and long-term care facilities. We present information sessions—public lectures—to community groups to raise the awareness of Alzheimer's disease among the public. We support biomedical and care research and we monitor publications for any progress in managing the disease.

We have a strong presence in the community. Our volunteers and donors contribute significantly to the services we provide, and they associate closely with the chapter's mission, focused around these services. In order to keep volunteers and donors, we believe that existing agencies need to retain a degree of their own identity and

mission. We fear that if services are mandated, funded and governed by fully integrated MSAs with no role for individual agencies, neither the volunteer hours nor the donor dollars will be forthcoming, and those donor dollars now make up about 40 per cent of the services we provide.

In addition, we all know that there will be important programs and services that will not be funded or mandated under the MSA. If voluntary organizations like our chapter have no role in the MSA, will they be viable to carry on these extra but crucial functions? We therefore suggest a continued role for individual agencies within the MSA model. In terms of governance, we suggest that the agency's board of directors could be transformed into service advisory committees that direct the activities within each service category, and to provide proportional representation on the MSA board that would manage the funding envelope. We will elaborate in our written submission on a possible model, and we have a nice diagram that outlines our vision.

Thank you very much for your attention at this time of the day, and Dr Galloway and I would be pleased to answer questions.

The Acting Chair: Thank you very much for your presentation. We appreciate your coming before the committee today. There's time for really only one question, and if all of the committee members are willing to pass, that would make life a little easier because I know that all caucuses would like to have some time, unless there's somebody that really has an urgent, burning question. Mr Jackson, urgent and burning?

Mr Jackson: Urgent and burning, since I made a request of Mr Quirt about those MSAs' plans which have been filed, and I've not as yet seen that plan, and the question has to do with the degree to which much of what you shared with us, Gertrude, and is being looked at by those committees that are currently working in Halton, which is more the civic reference point, with respect to some of the points you've raised and an alternative model, because the political answer is, it's all up in the air and there could be some flexibility. Have you shared that with the local planning and is it included in the one that's been submitted to the minister? At least the draft, I'm told, may be already at the minister's office.

Ms Cetinski: We have submitted our ideas about the MSA to both the Halton District Health Council and the Hamilton-Wentworth District Health Council, and since I'm a member of the long-term care committee in Halton, I know that the call for ideas and those submissions have been looked at.

The Acting Chair: Thank you very much for coming before the committee today. We'll look forward to receiving your written presentation as well. Thank you.

The last presentation of today—

Mr Wessenger: I wonder if Geoff could clarify that.

The Acting Chair: Geoff, did you want to make a—

Mr Quirt: Just to clarify, Mr Jackson is quite right. I promised to provide the MSA submission made to the minister from the Metropolitan Toronto District Health Council and the minister's reply. To date, that's the only

recommendation the minister has received specific to MSA development. But that will be coming to you and will be available Monday for you.

The Acting Chair: Okay. Just to reiterate again, before Dr Deadman comes forward, I think everybody heard that the—what was the booklet?

Mr Quirt: Manual.

The Acting Chair: —manual is available, and if you will tell Mr Quirt where you'd like it delivered tomorrow, it can be delivered to you tomorrow. If not, you'll receive it on Monday at committee.

Mr Quirt: May I presume that people would like it delivered tomorrow to their Toronto office? If you'd like a different location, then let me know. So it will go to your Toronto office tomorrow unless you would like it somewhere else, and we'll send it anywhere you'd like as long as you let me know where.

The Acting Chair: Just talk to him privately and tell him which you prefer.

Mr Jackson: Bring it to Thunder Bay on Sunday night, please.

The Acting Chair: For those who are going to have to leave before, the committee will be sitting on Monday, August 22 at 9 am in Thunder Bay.

ASSOCIATION OF ONTARIO PHYSICIANS
AND DENTISTS IN PUBLIC SERVICE,
HAMILTON REGION

The Acting Chair: I'd like to ask Dr Deadman to come forward, our last presentation of the day. Welcome, Dr Deadman. You represent the Association of Ontario Physicians and Dentists in Public Service, Hamilton branch. Welcome. You have up to 20 minutes for your presentation. It's nice to see you again.

Dr John Deadman: Thank you very much, Madam Chairman. I appreciate the opportunity to be here, and I think it's perhaps timely that I followed the Alzheimer Society because we have a number of concerns in common.

My name is John Deadman. I'm a psychiatrist employed at Hamilton Psychiatric Hospital and I've been with the Ministry of Health for over 30 years. For most of that time I've been doing community work rather than institutional work in the conventional sense of that term, even though I've been employed by a large institution over most of that time.

My reason for wishing to make a presentation to this committee concerning Bill 173 is that I'd like to make the point that most of psychiatric practice is really long-term care, and therefore I think that psychiatry has a vital interest in the kinds of legislation and the kinds of systems that are being established for long-term care.

Between 1977 and 1983, I was part of a team in the Ministry of Health which set up and managed the adult community mental health programs which were later known as the community mental health branch. I make that point because I've really been doing community work, and I really don't see that one can make a clear and formal distinction between institutional work and community work. If they don't work together, they don't work.

I don't have a written submission myself, but our association will be presenting a written submission because other members of our association will be presenting to this committee in other venues, and so a written submission is being prepared and will be presented at that time.

I'm speaking partly on my own behalf but partly and perhaps largely on behalf of the Association of Ontario Physicians and Dentists in Public Service. This is an association which represents physicians and dentists who work in various parts of the provincial government, but most, if not nearly all of our members, work in one or other of the ten provincial psychiatric hospitals. So this is the context from which I will be speaking.

These hospitals have undergone tremendous changes in the past 30 years, as have all other areas of mental health care. I'd like to present our perspective on long-term care and try to explain how it relates to mental health care.

Mental health care has been a government service for far longer than any other area of health care. We even existed before there was a Department or a Ministry of Health. In 1846, the Legislature of Upper Canada passed the Asylums Act which provided for the setting up of a provincial asylum for the care of "lunatics and others who could not care for themselves." It was really the beginnings of the mental health system in Ontario. That's almost 150 years ago.

1630

In the 1950s, there were 14 hospitals with over 20,000 beds in Ontario. The system now has 10 hospitals and a little over 3,000 beds. That's quite a dramatic change over the last 30 years or so. In the past 30 years, we've done an awful lot to move care to the community.

I would suggest to the committee that as an organized service run by government, we've been in long-term care longer than anyone else. I'm talking now about organized services run by the provincial government. I would therefore hope, and I would certainly want to make sure that our experience becomes part of the planning for long-term care, and I really think it's important that we do make this point.

Bill 173 unfortunately, as I read it, seems to completely ignore mental health. In fact, in places it refers to "physical disabilities," and it's quite clear that services for the mentally ill are not included. But my patients need these services too, and my reading of Bill 173 suggests that they could very easily be systematically excluded for care under the long-term care system.

My special interest is schizophrenia. This is a disabling illness that affects almost one person in 100. That's somewhere close to 100,000 people in Ontario. As with any illness, the degree of disability varies from person to person, but almost all of the sufferers from this condition can expect to have episodes from time to time in which they are quite unable to think clearly and have horrifying, frightening mental experiences which can sometimes drive them to suicide.

They are disabled in every sense of the term. This illness strikes in the late teens or early 20s, and unless they die by suicide or perhaps some winter are found

frozen in a back alley, they can live a reasonably normal lifespan. This means that they can have 50 years or more of disability. If that's not long-term care, I don't know what is.

There seems to be a presumption that all of these things will be taken care of in the mental health system. I'd like to make two comments on this. The first comment is that going back the 150 years almost that I mentioned a few moments ago, we've had to set up our own complete system because many years of stigma and discrimination against the mentally ill have meant that they really were not able to access the services that everyone else used.

I thought that under the health reform initiative, which has been going on over at least the last five years, we were supposed to reduce discrimination and duplication of services and the kinds of exclusionary clauses that prevented particular classes of consumers from accessing services they need.

In mental health, we've had to maintain parallel systems for most of that 150 years. I thought we might finally be getting to the point where we could begin to merge systems and work more closely together. My concern is that Bill 173 may make that more difficult.

The second point I'd like to make is that there's really no clear dividing line between mental and physical disabilities or problems. Many mental disorders have physical problems associated with them and vice versa. For example, people with Alzheimer's dementia, which the group just prior to my presentation were talking about, which is a clearly defined physical problem, all seem to develop some behavioural and mental problems as part of the course of their illness. These must be managed, and they can't be effectively treated if we've got two parallel systems that are essentially separate and unfortunately don't talk to each other enough.

Not only is the continued separation between physical and mental health discriminatory to the people who happen to suffer from, particularly, I would suggest, mental health problems, but it's rather impractical as well. My concern is that Bill 173 may serve to perpetuate this division rather than bringing people together on these matters as I hoped the health care reform initiatives were intended to do.

I might say that the ministry seems to recognize this point because under the mental health reform initiatives which are presently very much preoccupying us in the mental health area, a working group has been established by the ministry to look at the interface issues between mental health and long-term care.

As I read Bill 173, I don't see any acknowledgement that this sort of process is going on. I wonder what the Minister of Health will do if she is presented with a set of recommendations from the working group which are in conflict with some parts of Bill 173. It is possible that by the time this group presents its final recommendations to the minister, Bill 173 may have already been passed by the Legislature and that would mean that it couldn't be easily changed at that time.

My concern is that if this were to happen, the mental

health reform initiative may have been rendered somewhat pointless, because as I said before, long-term care is a central part of just about everything I do as an institutional practising psychiatrist and as a great many of other psychiatrists do as well. At the very least, it's going to create some awkward difficulties for the legislative process.

But perhaps our biggest concern is that the bill is far too detailed and prescriptive. As everyone I'm sure around this table recognizes, legislation is extremely difficult to change. Once it's passed into law it becomes really quite difficult and could take years to bring in even the simplest changes.

That is why it has been customary to place in legislation only the general principles that we must follow, and the detailed prescriptions for the actual carrying out of the act go into the regulations. These regulations, of course, can be changed by order in council, and that's a much easier process if it turns out that there are really serious problems with some of the provisions and they prove to be unworkable in practice.

However, if something that's in the legislation proves unworkable, it can be an albatross around all of our necks—and I'm thinking of myself as somebody who has to carry out legislation—for many years to come.

Many other presenters have commented on the "arbitrary"—and I use the word "arbitrary", so I'll put that in quotes—the "arbitrary" limit of 20% on the amount of contracting out for service that can be done by MSAs. I don't want to go into that in detail because this is much more of a concern for other agencies than it is for us. But my opinion on this is that it's going to prove absolutely unworkable and it's going to prove that way very quickly if the law is passed in its present form. The enforcement of it would be very difficult—I certainly wouldn't want to be the bureaucrat that would have to enforce it—and if it were rigorously enforced, it could be very disruptive to the existing system. It might even have the potential to cause collapse of services, because at the present time, long-term care is very dependent on a range of rather large and well-organized community services, and if they were restricted to 20% of the service provision, a good many of them effectively are going to go out of business. I don't see any alternative to that.

However, as I said, this is not perhaps as much a concern for us in psychiatry as it is for the people in those particular agencies. I might say that our own mental health reform process is also encountering many problems and much criticism as well. We haven't even attempted to write legislation yet. I certainly hope, though, that by the time we get to that point, we will be very carefully trying to avoid some of the pitfalls that I sense may be contained in Bill 173, and I thought therefore I really appreciate the opportunity to make a presentation to the committee because we do feel that Bill 173 in its present form makes our task in mental health reform much more difficult.

Mrs O'Neill: Dr Deadman, thanks so much for coming. We did have one group present to us on geriatric needs and we really felt that they were not attended to, as did they. We received a technical briefing at lunchtime,

you might be interested. It's eligibility criteria we had asked for, and it states in it, "Eligibility for Community-Based Services, Broad Criteria."

And number 4 of that broad criteria is, "Needs cannot effectively be met by other resources in the community or by other government programs where appropriate." The explanation of "other government programs" is the "mental health systems," whatever that means. I will certainly give the ministry staff a chance to explain that more broadly if they feel they can, but it looks like mental health is just completely eliminated from Bill 173 at the present time.

Dr Deadman: That was certainly my reading of it too, and our concern is that there are many things that we might be able to provide through the mental health system, but we're really talking duplication of service here at a time when costs are such an important factor that we're really trying to avoid duplication of service.

Mr Jim Wilson: Thank you, Doctor. I just along the same line wanted to ask you for a couple of examples of things that the mental health working group might recommend that would be in conflict with what you've read in Bill 173. Can you think of anything off the top of your head?

Dr Deadman: Well, the one thing that they are working on is how we can get better working relationships between—well, I'll use the example of Alzheimer's patients, because that is probably the best example I can think of right now. These are people who have a progressive dementia which can progress very, very slowly, maybe over quite a number of years, and during that time they get various kinds of behaviour disorders. Some of them can show psychotic symptoms—which are often confused with schizophrenia, although we can usually tell the difference; I'm not sure we can always tell the difference—and if they get put in a mental health system, they're really treated for their mental health problems, but it's difficult then to get services for their many physical problems. And they have a lot of physical problems. It means transferring them back and forth between institutions, which can become very difficult.

The one thing that the working group, and I have no idea what they're going to recommend because they

haven't got to that point yet, but one thing that they could very well recommend is that specific institutions be set up that would deal with both kinds of problems at the same time. And unfortunately, if they're going to be under the rubric of long-term care, I wonder how they would fit with the multiservice agencies. I wonder how they would be put under that because they certainly, at least for those patients, would represent not more than—well, there are a lot more than the 20% that's stipulated. They would be, for those particular patients, 100% of their care.

Ms Carter: Dr Deadman, you have said that you are aware of the long-term care mental health interface work group, and also I understand that in the fall of this year this will be a consultation with key stakeholders to seek input on implementation strategies, so the government is well aware of this lack and is working on it.

Now, it's my impression that there is nothing in the act that makes it impossible to add to the basket of mandated services. Am I correct in that, that this could be added without us having to go back to new legislation? Could that be confirmed?

Mr O'Connor: The basket as described in the legislation is the minimum.

Ms Czukar: As long as the minister approves.

Mr O'Connor: As approved by the minister, yes.

Ms Carter: Yes, so that if it were agreed that this should be added, that could in fact be done without delay or a cumbersome process. So I think you can be reassured on that point.

The Acting Chair: Dr Deadman, thank you very much for making a presentation. The committee will look forward to the written presentation from your organization, and I know that according to the schedule we will be hearing from them in other locations.

Dr Deadman: Yes.

The Acting Chair: For all of you who've sat here for the day of public hearings, I hope that you've found it interesting and enjoyable. I know that all the committee members enjoyed hearing the presentations. The committee stands adjourned.

The committee adjourned at 1645.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Chair / Président: Beer, Charles (York-Mackenzie L)

***Acting Chair / Présidente suppléante:** Caplan, Elinor (Oriole L)

Vice-Chair / Vice-Président: Eddy, Ron (Brant-Haldimand L)

***Carter, Jenny** (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

***Martin, Tony** (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

***O'Neill, Yvonne** (Ottawa-Rideau L)

***O'Connor, Larry** (Durham-York ND)

Owens, Stephen (Scarborough Centre ND)

***Rizzo, Tony** (Oakwood ND)

***Wilson, Jim** (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Caplan, Elinor (Oriole L) for Mr Beer

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

Kwinter, Monte (Wilson Heights L) for Mr McGuinty

Malkowski, Gary (York East/-Est ND) for Mr Hope

Sullivan, Barbara (Halton Centre L) for Mr Eddy

Wessinger, Paul (Simcoe Centre ND) for Mr Owens

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Boucher, Joanne, research officer, Legislative Research Service

CONTENTS

Thursday 18 August 1994

Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,	
projet de loi 173, <i>M^{me} Grier</i>	S-1779
Ontario Community Support Association, areas 4 and 15	S-1779
Helen Schultz, director, area 15	
Jessica Brennan, director, area 4	
St Elizabeth Visiting Nurses' Association, Hamilton-Wentworth; Visiting Homemakers Association	
of Hamilton-Wentworth; Victorian Order of Nurses, Hamilton-Wentworth branch	S-1782
Ken Bistrovich, VON board member	
Betty Muggah, director, VON home care program	
Mike Pennock, VHA board member	
Rita Soluk, SEVNA president and chief executive officer	
Jacqueline Balfour	S-1784
St Joseph's Health Care System	S-1787
Sister Joan O'Sullivan, vice-president	
Brian Guest, executive director	
Canadian Red Cross Society, Ontario division, west central and central regions	S-1789
Heather Richardson, director, homemaker program, west central region	
Della Crozier, volunteer	
Diane Pick, volunteer	
Ontario March of Dimes, Niagara regional office and Hamilton regional office	S-1792
Maureen Lamarre, independent living manager, Hamilton region	
Doug Overy, independent living manager, Niagara region	
Regional Municipality of Niagara	S-1794
Roy Adams, chair, community and health services committee	
Bev Goodman, manager, community programs, senior citizens' department	
Ministry of Health	S-1798
Paul Wessinger, parliamentary assistant to the minister	
Geoff Quirt, acting executive director, long-term care division	
Gail Czukar, legal counsel, long-term care legislation	
Jean McCartney, manager, program design, policy branch	
Ontario Dental Hygienists' Association	S-1808
Elizabeth Craig, executive director	
Linda Berry, chairperson, government relations	
Victorian Order of Nurses: Guelph-Wellington-Dufferin, Halton, Niagara and Waterloo region branches	S-1811
Cherry Cross, vice-president, Halton region	
Dan Toppari, board member and past president, Niagara region	
Cori Phillips, president, Guelph-Wellington-Dufferin region	
Coalition of Community Health and Social Service Agencies of Hamilton-Wentworth	S-1815
Norma Walsh, past chairperson	
Nancy Long, representative	
St Elizabeth Visiting Nurses' Association	S-1817
Rita Soluk, president	
Wellington-Dufferin-Guelph Health Unit	S-1820
Dr Douglas Kittle, medical officer of health and director	
Hamilton-Wentworth District Health Council	S-1822
Barbara Mahaffy, chair, long-term care committee	
Respirom-Care Plus	S-1824
George Farnham, president	
St Joseph's Villa	S-1826
Paul O'Kafka, executive director	
Margaret Lambert, director, SJV senior centre	
Alzheimer Society for Halton-Wentworth	S-1829
Gertrude Cetinski, education director	
Association of Ontario Physicians and Dentists in Public Service, Hamilton region	S-1832
Dr John Deadman, past president	

S-62



S-62

ISSN 1180-3274

**Legislative Assembly
of Ontario**

Third Session, 35th Parliament

**Assemblée législative
de l'Ontario**

Troisième session, 35^e législature

**Official Report
of Debates
(Hansard)**

Monday 22 August 1994

**Journal
des débats
(Hansard)**

Lundi 22 août 1994

**Standing committee on
social development**

**Comité permanent des
affaires sociales**

Long-Term Care Act, 1994

**Loi de 1994 sur les soins
de longue durée**

Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Monday 22 August 1994

Lundi 22 août 1994

The committee met at 0933 in the Valhalla Inn, Thunder Bay.

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

The Acting Chair (Mr Dalton McGuinty): Good morning, ladies and gentlemen, and welcome to the standing committee on social development continuing hearings in the matter of Bill 173, An Act respecting Long-Term Care. The committee is pleased to be here in Thunder Bay and we look forward to hearing from you this morning and maybe this afternoon as well.

ONTARIO NURSES' ASSOCIATION, REGION 13

The Acting Chair: Our first presentation will be made by representatives of the Ontario Nurses' Association, region 13, and I ask those people to step forward, please.

While you are taking your seat, I'll take advantage of the opportunity just to go over some of the ground rules to make sure folks understand that we have allotted one half-hour for each presentation and that time is to be used as you wish, but we would ask that you allow the committee members time to ask questions because we're very interested in this matter. Would you please begin by identifying yourselves for the record and then begin with the presentation.

Ms Judy Tinnes: Good morning and welcome to Thunder Bay. We are pleased to have this opportunity to address the standing committee on social development and share with the committee some of our concerns in regard to Bill 173, An Act respecting Long-Term Care.

Originally, when asked by Mr Arnott, the clerk of the committee, to identify ourselves and whom we were representing, I answered with no hesitation. I am Judy Tinnes, a public health nurse in Nipigon, representing the Ontario Nurses' Association as its legislative committee member, region 13. Levina Collins, on my right, is representing the volunteer sector and Nipigon District Memorial Hospital, and Linda Launderville, RN, is a home care nurse and case manager in Thunder Bay. After much thought and discussion, we sincerely believe we are also representing the consumers who utilize the services of the long-term care system and whom we work with daily. We are presently, and have been for years, our clients' advocates.

We will begin by saying we support the government in its efforts to reform the long-term care system. We

believe that community-based, long-term care and support services definitely need to be expanded and improved to serve more people in their own homes and own communities.

We are very pleased to see that the legislation, Bill 173, establishes a bill of rights and an appeals process for our consumers, comparable to the system now available to residents in our long-term care facilities. We are also very pleased to see that the legislation establishes an agency, or MSA as it is referred to, to coordinate community services, provide information on these services and create a desperately needed one-stop access to services for consumers. However, we would like to draw your attention to possible problems that may arise if numerous service delivery agencies are amalgamated and integrated into an MSA.

For example, we must make sure that MSAs do not become another government bureaucracy. Small communities like Nipigon should have control over their long-term care services. Centralizing services in a metropolitan area for a city could be most appropriate. However, an MSA located in a major city which also services rural areas is most inappropriate for the rural area. In our small communities of northwestern Ontario, the hospital is seen as the centre of health care. We have the administrative structure already in place and we believe, at little cost, these hospitals could become our MSAs. We hope the government will consider giving these communities the tools they need to develop and enhance their long-term care services.

We are also concerned that numerous community agencies that are presently delivering long-term care services in a very effective and efficient manner will be dismantled. We see a great number of employees and volunteers in these agencies either being hired by the MSA or being laid off. The government evidently believes that this integration, amalgamation and delivery of services will lead to a more cost-effective system. We believe not enough questions have been asked.

Let us first look at the volunteer sector. Numerous volunteers who have a passionate loyalty to individual agencies and have given hours of devoted service to that agency will now be under an MSA. Will they have the same commitment to this new, large, nondescript agency? Will they still fund-raise for moneys to be put towards the operating costs of the MSA, as they had with their previous agencies? Although this question has not been answered, from our contacts with the volunteer sector in our community, we think not. If the fund-raising doesn't continue, will the government make up the moneys to

continue the service? Will this be an added cost the government has not considered?

We also ask if other costs associated with the establishment of MSAs and their boards have been analysed to predict the cost-effectiveness of the new system. It appears to us that the MSA's role of funding, planning and management of health services will overlap the mandate of district health councils. This brings to mind the comprehensive health organization in the Rainy River area, which I believe has been designated as the MSA for that region. Is their mandate of funding and planning for health services not part of the mandate of the Kenora-Rainy River District Health Council? How is this leading to savings and more cost-effective planning? Why would two agencies or councils plan health services for the same region?

We previously mentioned two scenarios for service providers presently working in the long-term care system: working for the new agency or being laid off. We mention layoff specifically in relation to service providers under professional services. On page 18 of the compendium, it states: "The act does not specify what professional or trained non-professional must be employed to provide a certain service. This will permit alternative, lower cost workers to provide services if the task or procedure is not restricted to a specific scope of practice under the Regulated Health Professions Act." Therefore, only the RHPA will determine when a regulated health professional will be required. Will this tempt the MSAs to use lower cost staff for all services except those requiring professionals to carry out controlled acts under the RHPA? Lower cost staff does not necessarily equate to savings in the long term or providing the consumer with the most appropriate care.

0940

We recommend that the initial assessment of a consumer entering the long-term care system be carried out by a registered nurse.

Many of you on the committee at this point in our presentation are possibly thinking, "Here's another interest group protecting their jobs as nurses in the new system." Are we turf-protecting and trying to advance our professional interests? We think not. Nurses have always been advocates for their clients; consumers of the system deserve the best. Many entering the long-term care system today are frail, elderly persons with numerous acute and chronic conditions. Many of these consumers are cognitively impaired. We believe that if this reform is to be successful in its objectives, the consumers entering the system must undergo a professional assessment by a highly educated and trained registered nurse.

Registered nurses come with a holistic, educational background and a great wealth of experience. They are skilled at developing relationships, both with their clients and families, and have a great understanding of the community agencies and services that exist. They are skilled coordinators. They are skilled assessors. They have been trained and educated to offer a broad-base assessment in regard to physical, emotional, spiritual, psychological and social needs of clients. They are trained and have gained experience to coordinate complex cases and follow clients

through the maze of the health care system. Registered nurses are there at all stages of the life continuum, from birth to death.

Registered nurses also accurately receive and process referrals. Dangerous mistakes can be made if inappropriate staff accept these referrals. Nurses have had years of experience with medical language and pharmaceutical terminology and can process physician referrals correctly and quickly. Without the proper training, time and supplies as well as human resources can be wasted. Referrals and initial assessments must be done by the registered nurse if this long-term care system is to be efficient and cost-effective.

Bill 173 must state that the person hired to receive referrals and do the initial assessments of clients must have a registered nurse's background.

Ongoing assessments and monitoring must also be done by registered nurses. Many consumers utilizing the services of the long-term care system become increasingly ill and their health status can change rapidly. Registered nurses have the skills to recognize complications sooner. They can also assess if their clients' needs are being adequately met. This, in turn, will lead to a more cost-effective and responsive system.

Our last comments are related to labour adjustment. If proposed amalgamation of numerous service provider agencies into MSAs does take place, a labour force plan will have to be initiated. We recommend that the committee ensures that there is expertise on the MSA boards to deal with the complex issues that will arise. As ONA members, we also recommend that there is fair representation of front-line workers on the board, as well as on any human resource planning committees. Successor rights must be addressed. We know ONA members will participate responsibly and effectively to ensure the success of the long-term care reform.

In concluding, we would like to thank the standing committee on social development for listening to our concerns. Although indications are that decisions have already been made by the government, we would hope that our submission will be openly considered with a view to revising the original act. We believe government and government decisions can only be improved by involving its citizens. We look forward to working with you in the future.

At the end of the brief, I have attached our conclusions of the bill and also the recommendations.

The Acting Chair: Thank you very much. Committee members, we have roughly 15 minutes for questions and we'll begin the rotation with the Liberals. Barbara Sullivan.

Mrs Barbara Sullivan (Halton Centre): Thank you very much and welcome to our first session in northern Ontario. We're quite interested in the particular issues that you've raised with respect to delivery of services in the north. I should tell you that we have heard the argument for including case management as a professional service and in fact our party, I believe, is putting forward an amendment to that effect. We think that would be an important step forward.

I'm particularly interested in the issues that you've raised with respect to labour adjustment. Our view is, and at the hearings we have heard, that people wanted a multiservice agency rather than a monopoly.

Failure of sound system.

Mrs Sullivan: Just to save time, I'll move on into the query with respect to the labour adjustment issues.

We understand, given the model of the multiservice agency, which will be a monopoly on both services and access, that existing agencies, whether it's Red Cross, VON, Saint Elizabeth or other care delivery agencies, home care, will in fact be put out of business because there will not be an adequate base for which the MSA can purchase services outside. Therefore, there will be little reason and in fact little monitoring sense for those other existing agencies to stay open.

We were told last week by the director of long-term care in the ministry that the government would pay the cost of severances for those people who will be put out of work. You have raised the issue of a different level of services, ie, using a paraprofessional rather than a professional to deliver services.

I'd like to know what you think, what your reaction is to the government putting a whole bunch of money into severances for people who are delivering care in an appropriate way now when in fact any additional money should probably be going into additional services and not into disrupting the system.

Ms Levina Collins: I can try to respond to that. I think you're trying to ask me, do we want the money for a severance package so that the clients will no longer get what we feel is quality or do I feel that you should put the money into providing higher quality, and I don't really think that's totally fair of you, but I do feel that if the government goes ahead and does decide to use lower quality service providers, and you are going to lay people off, it is only fair, if you deliberately do that, that you do offer a severance package.

But I feel that the system at the present time does give quality care. Professionals are used in the assessment and the delivery of service and it's the professionals who do the total assessment and then it is the professional who decides what level of care the consumer requires, in conjunction with the consumer. I certainly feel that the money should be there to be allowed to provide that care.

Mrs Sullivan: Is it necessary there to throw out the existing system to bring in a new system that will cost a lot more money, including in labour adjustment, whether it's the wage parity issues, whether it's in benefits, whether it's in pension plan changeovers or in severance? Wouldn't it be better to enhance the existing system by improving coordination than introducing a new agency that has a monopoly on services?

Ms Collins: I feel that is what we have been trying to tell the government all along, that it is best to enhance the present system, increase the mandate and give the consumer the one-stop access that they have been asking for and that we have been begging to have our mandate increase so that we can offer the system. Don't tie the hands. Increase the mandate and enhance the system, and

that probably will be the best, most cost-effective and efficient system you could provide.

Mrs Sullivan: I probably have a little bit of time left. You represent union nurses. Have you spoken with your nursing colleagues who are in non-union situations about how the labour adjustment issues will be handled?

Ms Tinnes: Non-union workers?

Mrs Sullivan: Yes.

Ms Tinnes: I think what you see in community care services is professionals and non-unionized people making less money than people who work already in the institutional section. So I think when the labour adjustment concerns are going to come forward, of course, if this MSA takes places, that non-unionized members have to be taken care of, as well as unionized members—definitely.

Mrs Sullivan: Thank you.

0950

Mr Cameron Jackson (Burlington South): I was interested in the comment you made on page 3 with respect to the DHC and its designation as an MSA. I guess the first part of my question, if I can get a short answer from Mr Quirt, is the question I asked two weeks ago: Where's the list of those that are before the minister and have any approvals been made or under active consideration? If I can get a straight answer on that, then I can build on a question I'd like to pursue.

Mr Geoff Quirt: As I mentioned last week, the minister has received only one submission from a district health council on the formation of multiservice agencies. That's the submission from the Metropolitan Toronto District Health Council asking for the minister's endorsement of its work to date recommending 15 to 20 MSAs in Metro. A copy of the Metro Toronto submission and the minister's reply—

Mr Jackson: All right. I'm sorry to interrupt you, Mr Quirt. You've not received anything at all from northern Ontario that's been sent to the Ministry of Health at all around this issue?

Mr Quirt: I know that long-term care planning committees in northern Ontario are working on the MSA issue currently. No, they have not submitted a formal recommendation to the Minister of Health.

Mr Jackson: And none of the pilot projects that have been encouraged to fast-track their proposals, none of them in northern Ontario have had even informal discussions with your ministry?

Mr Quirt: Our ministry staff, including our area managers in the north, are discussing on an ongoing basis the MSA and its establishment in each northern community. So discussions have been ongoing. To date, I'm not aware of any particular proposal for either an early leader MSA or I'm not aware of any district health council recommendation to the minister on the subject. I know a lot of hard work's going on in that regard, but no, nothing's been sent to the minister yet.

Mr Jackson: So the comments on page 3 in this brief are being presented to you today for the first time?

Mr Quirt: I'd ask the member to point out to me

which comments he's referring to on page 3.

Mr Jackson: In the first paragraph: "This brings to mind the comprehensive health organization in the Rainy River area which, I believe, has been designated as the MSA for that region. Is their mandate of funding and planning..."

Mr Quirt: No, that's accurate. The minister has endorsed the establishment of a CHO, a comprehensive health organization, in Rainy River, and yes, given the nature of a comprehensive health organization, in discussions with the DHC in the community, it's been confirmed that it was logical for the CHO to assume the multiservice agency function for that area.

Mr Jackson: Okay, fine. I'll use your semantics since the ones I'm using aren't getting me any information. Could you tell me what you classify that and how many more of those you have actively been considering in the province? Because up until this very moment, all we've heard is one little proposal out of Metro Toronto. Now you've confirmed to me that the minister's formally endorsed a CHO becoming an MSA in Rainy River.

Again, Mr Chairman, this is a matter of privilege for members of the committee. As the senior staff member travelling at huge expense in the province of Ontario, we should at least get the facts when we're asking for them.

Mr Quirt: I apologize to the committee if I've misled it. I did not consider the MSA development discussion at the long-term care planning committee level as being synonymous with discussions about comprehensive health organizations that affect a broad range of programs and services, including long-term care, and in terms of specific MSA recommendations, the only thing that's been received has been the one from the Metropolitan Toronto District Health Council and that's been shared with you this morning.

Mr Jackson: Mr Chairman, I'm somewhat distressed to be learning this. I specifically referred to my visit through northern Ontario because I knew I was going to be receiving deputations from similar individuals from when we were here on Bill 101, where their vision of how an MSA should be constructed was shared with members of this committee. There are only a few, but there are some of us who are common to all those public hearings in the north.

Now I'm finding out that such a configuration has been approved by the government and the deputants now come before us with some legitimate questions to be raised and we are at a bit of a disadvantage not having had the time to examine them in more detail. I suspect you're going to tell me my time is running out.

The Acting Chair: Yes, I am. Mr Jackson, there's approximately one minute remaining. The parliamentary assistant wishes to make a comment. It's your time. Do you want to hear that now?

Mr Jackson: No, he can raise it on the government's time. I would simply like to ask the deputants then, to what extent were you involved in the discussions which led the minister to endorse the CHO as becoming the MSA for the Kenora-Rainy River area, and are your questions unsatisfied with respect to those discussions and

that's why you've come forward today to try and get some straight answers about what's going to happen?

Ms Tinnes: Yes. As the legislative committee rep for ONA for region 13, and it does cover the Rainy River area, I was not personally involved with the meetings but other ONA members were. I understand that this CHO was designated as the MSA in March of this year by the Minister of Health, Ruth Grier, and I believe that they're still having ongoing discussions. I understand just recently that one of the towns within that area, Atikokan, is not joining the CHO, even though it's in that region.

The Acting Chair: Thank you. Mr Wessinger, parliamentary assistant.

Mr Paul Wessinger (Simcoe Centre): I'll just make a comment, that I think really that it's always been anticipated that the CHO in Rainy River would always involve the MSA function. I think that's always been part of a policy decision, but I'd like to just go to the brief, and I'm going to try to be quick because I think some of my other colleagues would like to ask a question too.

I'm just going to raise one issue and that is your recommendation with respect to the question of front-line workers being represented on the board. By that, are you recommending that they'd be members of the board with voting rights or they'd be members with a voice but no vote or are you recommending some sort of structure that perhaps an advisory committee representing front-line workers be present at board meetings? I wonder what you mean by that. Are you flexible with respect to that recommendation?

Ms Tinnes: We do recommend that front-line workers sit on the board with voting privileges. We know that in the hospital sector there's a fiscal advisory committee, that ONA nurses have been representatives on those committees. I believe that it is in legislation that they are to be involved and it hasn't been too successful. We would like to see this again put into the bill.

Mr Larry O'Connor (Durham-York): The long-term care committee in this area, I know that many of the district health councils are a little further along, and I just wondered whether or not you've been involved in that process at the community level. This isn't a model that's trying to come from the top down—the local planning that's necessary and the commitment from the community to see this come from the bottom up, from the community level. So recommendations around assessment and what not have to be developed through the MSA, and I just wondered if you've been involved with the long-term care committee of the district health council and what your involvement is in the community trying to work with consumers to make sure that what we have then isn't the model from up top coming down.

Ms Tinnes: This past June, there was a long-term care committee that came to Nipigon with the rep from the Nipigon area, and I was invited to attend that meeting. I and the home care nurse in Nipigon took it upon ourselves to phone numerous citizens, elderly patients, senior citizens in their buildings and senior citizens in groups to come out to the meeting, and had this home care nurse and myself not done that, I think we probably would have been the only ones at the meeting.

Mr O'Connor: So for community involvement then, there hasn't been a way of reaching into the community or it hasn't happened well? Because this needs to be driven by the community. The community needs to know that this process is under way and, if nothing else, the committee hearings are going to let the community know that there is a change evolving here and it needs to have as much community involvement as possible. Do you have any suggestions how that could happen? I guess the district health council will watch what's being said here as well.

Ms Linda Launderville: I think that we need to get more information out to the consumers and let them know ahead of time to come out to the meetings because we were—myself, too—running around trying to get people to come to the meetings and things like that.

I'm not so sure that they're even listening to us, though. That's the feeling that we get, that they're not listening to the consumers, especially—

Mr O'Connor: The long-term care committee isn't listening?

Ms Launderville: We don't get that impression totally.

Ms Tinnies: We did recommend after that meeting in Nipigon that the newsletter that this district health council is preparing—the long-term care committee newsletter, which is excellent, but was getting to nobody. So we did make a recommendation that a lot of these people were put on the mailing list and that these newsletters were put in places in the community that people could pick up.

Mr O'Connor: Everyone who's receiving the number of services that are being provided through the multiplicity of agencies out there today should actually perhaps be receiving that newsletter?

Ms Tinnies: Yes.

Mr O'Connor: Good point. Thank you very much.

The Acting Chair: Thank you very much for your presentation.

Mrs Sullivan: On a point of order, Mr Chairman: I wonder if it's possible to eliminate the noise.

Interjection.

Mrs Sullivan: Oh, good, it's been done. All right.

The Acting Chair: It's being looked after.

1000

ST JOSEPH'S HERITAGE

The Acting Chair: Our next presentation will be made by Sister Bonnie Anne MacLellan representing St Joseph's Heritage. Good morning, Sister. Welcome to the committee. Please introduce your guest and begin.

Sister Bonnie Anne MacLellan: Good morning. Thank you. With me here today is Mr Grant Walsh, who is the chairperson of the board of management of St Joseph's Heritage. My name is Sister Bonnie Anne MacLellan and I am the executive director of St Joseph's Heritage, a tricomplex made up of a 109-bed, fully accredited nursing home, a 180-unit apartment complex and a community centre. I'm also the associate executive director of St Joseph's General Hospital, a 148-bed, fully accredited acute care hospital.

Thank you for providing this opportunity to address some aspects of Bill 173, An Act respecting Long-Term Care.

I would like to take this opportunity to commend the present government on proceeding with long-term care redirection legislation. The value of seniors in Ontario is obviously uppermost in the minds of the Ministry of Health policymakers. The government's goal to provide seamless services for all residents in Ontario, from conception to death, is supported. The concepts of wellness and aging in place have been encouraged by most health care professionals for a number of years. It is encouraging to see legislation which supports these fundamental dispositions. Approaching long-term care policy formation from this foundation will encourage individual independence, social interdependence and ongoing self-actualization throughout the lifespan.

Many of the concepts in the proposed legislation support the government's goal to help seniors age in place with appropriate supports and to minimize barriers to community-based service provision. There are, though, some major areas of concern that lead me to the position of speaking against the bill in its present form. These areas include the following: the definition of "adult day program," the impact of multiservice agencies on existing agency service provision, the 20% limit on non-MSA purchased services, shared costs for services and the expanded role of the district health council.

I would first like to address the issue of the definition of "adult day program." In the proposed legislation, the definition of an "adult day program" notes "a program of structured and supervised activities in a group setting for adults with care or support requirements." While the purpose of the legislation is to ensure appropriate access to community-based health services, the definition of "adult day program" is very broad. Would the day programs already established in acute care or long-term care settings, for example, medical day care, psychiatric day care, Alzheimer's and related dementia day centre and support services programs, be subject to this legislation? If these programs were placed under the jurisdiction of the multiservice agency, what would be the role and the authority of a local facility board?

Many organizations in the province have initiated and sponsored innovative and creative community outreach programs, often without government assistance until the program was proven to be successful. The government seems to assume the community outreach programs that are presently within institutions will continue within the institution and carry on the name and the logo of the facility. This is referenced in the government's document, *Partnerships in Long-Term Care*.

There is no way that communities and institutions will support in their facilities programs that are not part of the established organization. There must be no confusion or misrepresentation on this matter. Programs such as St Joseph's Heritage Alzheimer's and related dementia day program and St Joseph's Heritage support services program of the P.R. Cook Apartments, if they come under the jurisdiction of the MSA, will not remain as a program of St Joseph's Heritage. They would become

programs, perhaps housed in St Joseph's Heritage complex, but not having any connection to St Joseph's Heritage. To continue with the name without the philosophy and board support and management of our organization would be ludicrous, and lying to the public.

There is also the issue of staff commitment. The staff of St Joseph's Heritage Alzheimer's and related dementia day program and the support services programs of the P.R. Cook Apartments have as their foundation the philosophy and values of St Joseph's Heritage to create a place for all seasons.

I would suggest to you that Sister Leila Greco, the founder of St Joseph's Heritage, was years ahead of her time when she visioned the creation of an environment where people could come and age in place, not set apart from the community at large. I can assure you that the vision and philosophy of St Joseph's Heritage, which is well known and respected throughout the community of Thunder Bay, will not be transferred to a government bureaucracy. The hearts of the staff of St Joseph's Heritage are committed to the vision and the philosophy of St Joseph's Heritage and it is not associated with programs in and of themselves. This heart commitment is the result of being captured by this vision, being smitten by the love and care that is part and parcel of being a part of St Joseph's Heritage. I cannot support abandonment of these programs and relocation of them to the multiservice agency. The programs, our staff and, of greatest importance, the people we serve, will suffer.

As a member of the district health council's long-term care subcommittee, I am aware of what I believe to be the spirit and the intent of multiservice agencies. Coordinated by a locally elected board which would represent both consumers and other community representatives, the MSAs are intended to provide one-stop access to community health services.

The spirit of the legislation addresses a crying need of many consumers to make the system easier to access. Again and again, clients and their families repeat to me their frustration of not knowing who to call for specific health and support services in their homes.

Simplifying access to a myriad of community services will provide individuals the potential to receive appropriate levels of support and professional care in their home environment. Much of the research indicates most clients progress and heal more readily if they are not removed from their familiar environment and from family who provide physical, emotional and spiritual support and love.

While I support the intent of simplifying access to community services, I must also express grave concerns around the issue of placing all or nearly all community-based health and support services under the direction of one board, the MSA board. Most of the existing community support and health services organizations, for example, VON home care, have a proven track record of efficient and effective service delivery. Governance of these non-profit community agencies has traditionally been through voluntary boards that monitor program direction, implementation, efficiency and effectiveness. These boards have established community credibility and

are accountable for the services they provide.

Placing all community-based services under the direction of the MSA board negates the validity and effectiveness of previous governance structures. Are there any data to support the implication that one large board coordinating a vast array of services is more efficient and effective than the existing individual boards of the agencies providing services at the present time? The community, volunteers, staff and clients are aligned and loyal to individual agencies, not to government bureaucracies. Is there any indication that the consumers or providers associated with existing agencies that would be collapsed under the MSA board will transfer their support to the MSA board?

1010

If the major issue for consumers is access to services, why demolish some very good aspects of the present system, for example, smaller agencies with smaller boards? Smaller agencies and the boards associated with them provide an important catalyst to continuous quality improvement: competition. Amalgamation of community health and support services into the MSA melting pot may simplify consumer access to services, but at the potential cost of quality.

Quality and excellence cannot be legislated or mandated from government. Quality and excellence come from individuals who are committed to the vision, the mission and the philosophy of the organization with which they are associated. With all due respect, these characteristics of commitment and excellence are not frequently associated with government bureaucracies. It would be a tragedy if our present effective community support and health service system was dismantled and replaced by a bigger, but not necessarily better, MSA model.

The question that must be asked again and again, as we contemplate this change or any other change, is: Will this change result in improved service from the point of access to in-home care provision for our clients? If the answer is not an unequivocal yes for all stages of the service delivery continuum, we must rethink our strategies.

In the legislation it clearly states that no more than 20% of the services provided by the MSA can be purchased from other service providers. This limitation restricts consumer choice. The MSA service provider will, in effect, become the only show in town. While the government seems to support a consumer-driven system, the only way the system will be truly consumer driven is if consumers have a choice in service provider. If only 20% of services can be provided by non-MSA agencies, how will consumers be able to choose providers which may, from the consumer's perspective, meet their needs more effectively than the MSA service delivery model?

For example, will a consumer in Thunder Bay be able to request VON as their visiting nurse over the nursing staff employed by the MSA? Will a consumer in Toronto be able to request a nursing visit from Saint Elizabeth Visiting Nurses rather than the nursing staff employed by the MSA? If the answer is, "The VON and Saint Elizabeth will cease to exist and will come under the structure

of the multiservice agency," how will there be any consumer choice in this model?

Before proceeding in this direction, it is imperative to reflect on our own experiences of monopolies. Did they provide better service than those situations in which there was competition? I think not. Quality and excellence will become a luxury only affordable to those who can pay privately for these services. Like Britain, we will share a two-tiered health system, something none of us could support.

In the proposed legislation, there are no cost-sharing agreements between consumers and providers. A number of years ago, Thunder Bay was fortunate to receive funding for a new and innovative integrated homemaking program. Like the programs noted in Bill 173, IHP was free and available to anyone who requested it. Within a very short period of time, consumer demand outstripped existing human resources and budgets. Some parameters for service provision had to be created. While these parameters were not monetary, they did provide some control mechanism to ensure that clients in greatest need were able to access homemaking services.

Eighteen months ago, the government supported a support services program at St Joseph's Heritage P.R. Cook Apartments. The program was given 70-30 funding, with the consumer paying for 30% of their service contract. While it would have been much easier to establish and provide a program that was 100% funded by the government, consumer copayments did many things. Copayments provided our consumers with a sense of control over the services that were provided in their homes. They were paying something for the services and hence felt they had a right to expect a certain quality and quantity of services.

While cost-sharing is not appropriate for all clients and for all services, failure to include this critical component may result in consumer demands which far exceed our ability to provide these services. This will increase waiting lists and consumer, as well as provider, frustration levels.

I'd now like to turn to the expanded role of the district health council. The Thunder Bay District Health Council has provided support for the coordination and planning of regional health services. Bill 173 expands the role of the DHC to include aspects of planning, implementation and resource allocation. If the authority of the DHC is enhanced to include organizational strategy development and implementation, the legitimate role and responsibility of local governing boards will be in question. It will be important to always place institutional health care planning within a broad systems perspective. An analogy could be considering the role of the DHC as macro-analysis and planning, and the institution's role as microsupport for larger health planning and strategy development.

Over the past week, in specifics, I have heard many people from across this province echo many of the same concerns regarding this legislation that I have today. The government's response has been consistent: "This has been the largest public consultation process ever embarked upon. We have consulted over 70,000 people."

While the number of people consulted may be correct, the question that begs to be asked is: Who made up these 70,000 people who were consulted? I can assure you it was not the frail elderly, who are the true consumers of community health and social services. These are the true consumers who have no voice in this process. It is imperative to take the time to ask them how they feel about the services they are receiving from local service providers, by the VON, by Red Cross homemaking, by St Joseph's Heritage Alzheimer and related dementia programs, by the St Joseph's Heritage P.R. Cook support services program and many, many others. Many, if not most, would say they were very pleased with the present delivery model, so why change the model?

The issue of consultation is raised by this government again and again as a victory flag of social awareness and consciousness, proving that the government is really the voice of the people. The issue here is not an issue of consultation; rather, it is an issue of what the government has done and will do with the information gleaned by the consultation process. To embark on a consultation process and do nothing with the data obtained is both fruitless and frustrating.

Here, I refer specifically to the excellent research completed by the Thames Valley DHC on Britain's and Europe's experience of models of community health and social service delivery models that are identical to the MSA model proposed in Bill 173. Research in these countries has proven that collapsing all community service providers under the one board and banner of the MSA has proven to be ineffective and inefficient. If this is what the research in comparable models is revealing, why would we ever want to duplicate what has been tried and proven to be ineffective?

My final points on this process of the government's consultation for Bill 173 are really a number of questions. This legislation appeared for the first time in print in July 1994. The consultation of the people of Ontario has been scheduled for two weeks in August. Why is it that this government seems to only present legislation that will stir controversy during the summer months when many consumers and providers are away? If the government really wants to consult both providers and consumers, why is the consultation time frame so short? Why have the people of Ontario only received the proposed legislation just prior to third reading of the bill? Once Bill 173 has had third reading it will be law.

Because of the timing of these public hearings, I have absolutely no confidence that any of the concerns raised throughout the consultation time frame will be taken into consideration in any amendments.

In closing, I do support the original spirit which provided the catalyst of this legislation. It is imperative that access to community health and social services be simplified. There certainly should be one-stop access to these services for all who need them. This is where the legislation should stop.

The development of the MSAs model under the existing legislation will destroy a proven and effective system of health and social service delivery in the province of Ontario, create monopolies and eliminate con-

sumer choice in the selection of service providers. There will be only one service provider, the MSA.

I would strongly encourage the government to listen to the concerns that have been raised throughout these public hearings. We will gain nothing by not doing so and will unfortunately lose everything in the process.

Thank you for the opportunity to once again address this committee.

The Acting Chair: Thank you very much for your presentation. Before we move on to questions, I've been informed by our clerk that our technical people are experiencing some difficulties with sound and recording, so we will require a five-minute recess in order to make the necessary adjustments. We'll recess for five minutes and return for questions.

The committee recessed from 1023 to 1034.

The Acting Chair: I understand that they've remedied the problem and we can resume our hearings. There's approximately eight minutes left for questions. The technical people ask that we speak directly into the microphones, that we use our buttons before speaking and hit the buttons again when we're finished. The witnesses won't need to do that, but for those of us sitting around the table here that would be helpful to them. We'll begin questioning with Mrs Sullivan, please.

Mrs Sullivan: I think this is a superb brief and I particularly appreciated the comments with respect to the consultative process. My sense is that there wasn't a huge outcry among those who were consulted during that process to be rid of mission-based organizations, VONs, Red Cross or existing homemaking services. There was a cry for an improvement in the long-term care system, particularly in terms of access and increasing services in communities where they weren't that expansive.

I want to ask you particularly about an issue I think is important that you've raised in your brief. It's a little more technical. It relates to the adult day programs and how they will be provided, what the legislation and the ministry contemplates with respect to those adult day programs which were sponsored through facility-based organizations.

I think of the Alzheimer's programs here. In my own community, we have rehabilitative programs that work in concert with other long-term care programs that come out of hospitals. In Guelph, the new reconfiguration of the hospitals there has just had, as part of its functional plan, adult day programs that are targeted to long-term care clients approved, and I think we need to know more about what happens to those facility-based adult day programs in a long-term care spectrum, if you would like to comment more on the effect of the facility-based programs here in this community and perhaps we can get some response from the ministry. There's an enormous confusion about this area.

Sister MacLellan: I'd be happy to respond to that. I'll respond specifically in relation to St Joseph's Heritage and the two programs that we have, which include the Alzheimer's and related dementia program and the support services program in the P.R. Cook Apartments.

It is our understanding that with the proposed legisla-

tion those would no longer be programs that our board will be responsible for. They may indeed be housed at St Joseph's Heritage, but that is where the connection would end. They would be leased tenants only. The staff would no longer be St Joseph's Heritage staff. We have a lot of concerns about that.

In the legislation they suggest that in communities where they see it's important they might continue with the name and the logo of the program if this is what the community wants. I want to be very clear that this will not be the case at St Joseph's Heritage, and in fact I would suggest to you that it's misrepresentation, because it has nothing to do with St Joseph's Heritage once the board has no longer any control over the quantity and quality of services that are provided.

Specifically in the Alzheimer's program, we have a subcommittee of our board that meets regularly that includes consumers, care providers and the Alzheimer's Day Centre, the Alzheimer's program in Thunder Bay. We meet regularly to discuss the program and to ensure that it meets the needs of the people of Thunder Bay.

We also, with the support services program, have another subcommittee of our board that reports regularly on the progress of the program and how we're meeting the needs of our clients. This will not be the case and so therefore it will not be a program of St Joseph's Heritage, which is a tremendous loss from our perspective.

Mrs Sullivan: Could the ministry or the parliamentary assistant or the officials respond to how facility-based programs will fit into this vision of long-term care change?

Mr Wessenger: Yes. I think perhaps I'll just respond briefly and then add Mr Quirt's comments for more details. I understand that we're prepared to look at flexibility with respect to the whole question of the delivery of programs by facilities. We certainly appreciate hearing the comments from the deputes here today and certainly the committee will, I'm sure, be looking at the whole question of dealing with this issue. I'll ask Mr Quirt to add any more particulars.

Mr Quirt: In terms of Bill 173 itself, it would have no direct impact on the operation of the Bethammi Nursing Home operated by St Joseph's. Bill 101, as you know, passed last year had significant impact on long-term care facilities, and the one connection between Bill 173 and the facility legislation is that the placement coordination services established under Bill 101, the placement function, would become part of the responsibilities of the MSA once the MSA is established.

With respect to the supportive housing program operated, there would be no direct impact on it. It would continue to be funded separately by the province. Clearly the MSA or other community agencies may make referrals to this supportive housing program, but that certainly is the case currently.

With respect to the Alzheimer Day Centre, in response to recommendations made by other presenters to the committee, it was indicated that the government is interested in hearing how the bill might be amended to allow for the facility-based day programs to be exempted from per-

haps the 20% purchase provision so that those day care programs that are an integral part of a long-term care facility would continue to be funded separately by the government as well.

In summary then, the nursing home isn't directly affected. The supportive housing program is not directly affected. The Alzheimer Day Centre: We're open to suggestions as to whether or not those day programs should continue to be funded separately and there be a referral relationship between the MSA and those day programs.

Sister MacLellan: I'd like to respond to that. I'm very pleased to hear that the support services program will not be included and will be funded separately, and I'm happy to hear the government's openness to negotiate our continued facility-based and institutional governance of the Alzheimer Day Centre program.

I would suggest to you that the bill, then, in its present form is misleading and subject to certain individual interpretation and will need to be clarified in order to address these specific issues.

1040

Mr Jackson: I had another line of questioning but I'd like to build on this, because there's a third piece of legislation, the Independent Health Facilities Act. If you draw an analogy here to, say, an abortion clinic where it doesn't necessarily have to be private, it can be a non-profit corporation and yet it still falls under the Independent Health Facilities Act—we're talking about standalone facilities and programs funded through an MSA, and those parts of the program that the MSA doesn't uptake, the balance of that program should, I would suspect, by definition fall under the Independent Health Facilities Act.

Are those limitations cross-transferable or are they not—Mr Quirt's only answered part of the question, in my view—and to what extent has the government analysed the implications of the Independent Health Facilities Act and its relationship if in fact some of these facilities are providing a medical model and a social support service model and so on and so forth?

Mr Wessinger: Yes, I'd ask legal counsel to clarify that issue.

Ms Gail Czukar: We're not saying that the adult day programs would fall outside the legislation. They would still be covered by this legislation. What could be done, depending on the feedback—and it's not really a matter of negotiation; it's a matter of responding to the input that we've had in proposing amendments to the bill down the line at the end of October, in clause-by-clause—is that these programs could stay under the bill but be given some kind of special status: those that are existing that are run by facilities to be exempted from the purchase limit that's in the bill or something like that. It would be a very limited exemption. We're not proposing to consider taking them outside the scheme altogether.

Mr Jackson: But in the absence of those amendments, at some point the Independent Health Facilities Act has to come into play by definition because, in order to survive, they're charging a fee for a service which

exists somewhere in an OHIP formulary but now is going to be provided on a fee basis somewhere else in the system. I don't wish to oversimplify the Independent Health Facilities Act, but I've spent six months of my life running around Ontario dealing with that bill and, as far as I'm concerned, I still see a strong analogy here.

Ms Czukar: I don't believe that we're discussing fee-charging under OHIP that would bring this kind of program under the Independent Health Facilities Act. What the presenters talked about is a program that's funded 70-30, and that's separate funding; that's not OHIP funding. So I don't see where the interface is, but maybe we need to discuss that further.

Mr Jackson: We will. I wasn't using the current example. I'm looking ahead to when they get their back to the wall where the local MSA says, "Look, we don't want to buy any of your service," but the decision is that because the demand in the community is such, they're prepared to provide the service. Well, to provide the service is now 100% fee-paying.

What restrictions will exist in Ontario law from them providing the service at full cost to any person who's rejected, turned down or on an extended waiting list for the services that have been designated by an MSA? I'm just fearful that the Independent Health Facilities Act will be the tool the government uses to say, "Sorry, you must shut down completely or apply to us for the licence in the licensing provisions that are contained in the Independent Health Facilities Act." That's all I was raising at this point. I was not using the specific 70-30 cost-share question; I was looking more to their concern about being phased out completely.

The Acting Chair: We're beyond our time, but I want to allow Mr Martin some brief comments and a question.

Mr Tony Martin (Sault Ste Marie): It's certainly good to be back in my own neck of the woods in terms of northern Ontario. I represent Sault Ste Marie and certainly have, over my short life, lived in almost every community in northern Ontario, as I'm sure you have, Bonnie, at some point or other in your service. Having lived in the north for a long, long period of time, certainly we've heard of the institution that you presently work for. When it was developed back a few years ago by Sister Leila Greco, we were all very envious of the opportunity that would provide to a small number of people in Thunder Bay, to get those services and to be looked after.

That perhaps was the beginning of our concern around the question of how we get equity into the system, how those of us who lived in Wawa and Elliot Lake and Red Rock and places like that got access to services of that sort. This bill is designed, to some great degree, to respond to that concern that I as a citizen of northern Ontario and that my parents who lived in Wawa and who now live in Sault Ste Marie have brought to the table in many interesting ways: How do we get our needs looked after? I guess the details of all of that will be worked out as it goes on. I think you're participating in a local consultation process and hopefully will involve the people you serve in that discussion, as I will in my community.

My hope would be that what you do at the Heritage and the spirit and enthusiasm that you bring to the Heritage are something that as well, through this process, could be made broader-based, that you could bring into the larger community. People like Leila Greco, who has now come to Sault Ste Marie and just recently retired from heading up the community mental health organization there, I'm sure when she left Thunder Bay, there was a great hue and cry that what she'd brought to the Heritage would be taken with her and brought to Sault Ste Marie.

I'm sure the experience was that in fact the seeds she sowed have produced a lot of good fruit. She came to Sault Ste Marie and, in a community-based organization, brought that same spirit and enthusiasm and developed some wonderful and exciting programs there.

I guess my question is, cannot that happen? Cannot the experience, energy and enthusiasm that you bring to your particular organization somehow be brought to a larger MSA process? Cannot that be helpful, then, to all of northern Ontario in some significant ways through this process?

Sister MacLellan: As you are aware, I am involved in the process of developing the MSA model here in Thunder Bay. When you talk about enthusiasm and commitment and passion in relation to service provision, those are usually related to the vision and the values of organizations. They're not specifically related to the services delivered, be it home care, be it nursing at the bedside etc.

People work for organizations for a myriad of reasons, but I think one of the bases of working for any facility is the organization's philosophy, values, mission and tradition. I would suggest to you that the MSA would have none of those that would entice me in any way.

1050

I'd also suggest that I've spent a great deal of energy in trying to work collaboratively to develop a good model that clearly meets the needs of the people in the community and I have worked passionately to move away from any kind of a model that suggests a bureaucracy in any way, shape or form.

Can I transpose the enthusiasm, the commitment of St Joseph's Heritage in the MSA model? The short answer is no. I could give you a longer one but I'm sure we don't have enough time. But I'm certainly committed to working at a process that facilitates access to services in the communities. Where I draw the line is when you dismantle existing organizations that have long traditions—a lot of this is based on tradition and the vision of founders—and visions of service delivery in the community that can't be transferred to the MSA model.

I'm afraid I don't share your enthusiasm or optimism regarding the MSA. I see it as being fraught with real problems and I would encourage you to read the discussion paper distributed by the Thames Valley DHC on January 7, 1994. There is an excellent literature review that looks at models comparable to the MSA that were developed throughout Europe and Britain and they're now reverting back to a managed competition system.

ST JOSEPH'S HERITAGE, P.R. COOK APARTMENTS

The Acting Chair: Our next presentation will be made on behalf of the P.R. Cook Apartments, St Joseph's Heritage. Welcome to the committee. Please make yourselves comfortable. I want to draw to the committee members' attention that 15 minutes has been allotted for this presentation as well as to the next one. Please introduce yourselves and begin.

Ms Anne Bowd: Good morning. My name is Anne Bowd and I'm the manager of the support services program in the P.R. Cook Apartments at St Joseph's Heritage. One of our support service program clients has come with us today and will give a presentation shortly. Her name is Mrs Marie Jean. We also have the moral support of two of our support service workers, Arlene Baker and Marg Smith.

The support services program provides services to tenants which enable them to continue to live in their own apartments, even when their service needs are quite extensive. The program helps tenants remain independent and delays or avoids placement in institutions.

We offer a variety of services, such as help with activities of daily living, which could include personal care as well as housecleaning. We offer meals, an emergency response system, daily "How are you?" checks, life enrichment and health promotion activities and outings in our van and the use of our swimming pool and sauna. Since the program started at the Heritage, we have served 81 clients, which represents 45% of our block. At the present time, we have 53 clients enrolled in our program.

I commend Bill 173 for the objective of seeking to ensure a wide range of community services as an alternative to institutional placement. Our clients tell us they do not want to live in a nursing home, and we have actually enabled several clients to die in their own apartments, as was their wish.

We would all agree, of course, that it is sensible to simplify and improve access to services. To this end, we feel that the multiservice agency should function as an information and referral centre. We should continue to use the programs that are already established and running efficiently and effectively.

A great deal of careful research and planning were necessary for the establishment of the support services program in the P.R. Cook Apartments. Because tenant needs are important and the services offered should meet individual needs and suit our particular clients, we entered into a consultation process with the tenants of our block. Through this process, we felt that we would learn what tenants wanted, what they needed and what they would pay for it. We were able to organize several packages of services that were consistent with the Heritage philosophy, to treat each person as a distinct individual and to enable each person "to age in a familiar setting while retaining as much independence and private life as possible."

The support services program was difficult to implement for a variety of reasons. Some of these were the cost, the difficulty of tenants realizing that they needed help, tenants not wishing to lose their independence, the

presence of other homemakers in our building, incomplete understanding of the services offered and tenants not willing to commit to a program they had yet to see in action. We worked hard to meet these challenges and to gently promote the program to tenants. People joined the program because it was a Heritage program and they knew that the staff would have a working knowledge of the Heritage philosophy and could be trusted. The tenants were aware that the whole St Joseph's Heritage history and philosophy stood behind this program and they so concluded, and I quote several tenants, "It must be good."

Tenants have an intense loyalty to St Joseph's Heritage. Three clients joined at the beginning of the program because they wished the program to be successfully established. I was told the tenants were pleased that the Heritage continued to remain at the forefront of service delivery and is "establishing a program ahead of everyone else."

The enrolment was slow when we first approached tenants, and two persons assured me that they would join even though they really didn't feel they needed the program yet. They were willing to put out the money so that the program could be started and people in the block could benefit from it. That's loyalty you would not see given to an outside agency, I'm sure.

Enrolment continues to be a concern, and it takes considerable time and effort to enrol a new client. This is partly because the program is not mandatory for tenants. They are offered a choice of whether or not to join the program. When a client dies or moves to a nursing home, we do not always fill that vacancy immediately and negotiations can carry on over a significant time period. If the program came under the multiservice agency umbrella, I have no doubt at all that the enrolment would fall dramatically.

The skills of the staff of the support services program combine to serve clients in all areas mentioned in the bill: support services, homemaking and personal support. There is no demonstrated need for differentiated staff for each area of client care.

We at St Joseph's Heritage serve clients in a holistic way. We see the areas where our clients need support, but we also see our clients' strengths, and we try to concentrate on these strengths and to enhance them. By doing this, we actually help clients to minimize their problems and to pursue activities that they have engaged in over the years.

The support services program is basically a cost-effective program. Staff time is used efficiently. Appointments can be booked for only 10 minutes if that is necessary to meet client needs. Travelling time is not paid. Staff response to emergency or crisis situations is immediate because staff are in the block, and this hopefully is able to prevent further complications.

Many students now seek placements with the support services program. This is because they receive a challenging learning experience and are supported well by staff and clients alike. Volunteers come and stay and find that the time they spend in the Heritage is rewarding. Volunteers have told us repeatedly that they have gained as much as they have given. Would students and volunteers

be as committed if the program were part of a large bureaucracy? I think not. The personal touch that helps people to feel valued and appreciated would be gone.

Many volunteers come to us because of the reputation that the Heritage has in the community. Without them, we would be unable to offer such an enriching program to our clients. We would not be able to individualize our services as we have done. Again, our clients would be the losers.

The bill states that client assessments and plans of service will include client involvement and that services will be planned, and I quote, in "as timely a fashion as possible." Currently, in the P.R. Cook support services program we are able to assess and enrol a new client immediately, all in the same day if necessary. We are able to respond to client concerns immediately. This is especially important in times of illness or crisis. There is no time lag before services are implemented, and we are in a position to prevent problems from worsening.

As a staff person at St Joseph's Heritage, I have always been empowered to develop my ideas and to try them. The mission statement and the values that we support at the Heritage have helped us to gain a reputation around the country for innovative services. I have communicated with people in Manitoba, Saskatchewan, Quebec and other regions of Ontario who have asked for information on the support services program. I presented a paper on our program at an international conference in Winnipeg in May. The conference was entitled, *There's No Place Like Home: Making it Happen*.

All the comments that I received at the conference were most favourable. Everyone mentioned the innovativeness of our program and wished that their province or state would fund such initiatives. When we were starting this program, I researched services within the province of Ontario and could find no other program providing services in the way that we were, that is, offering a choice of services to existing tenants in an existing apartment block. We have done something unique at St Joseph's Heritage. We worked hard to establish a successful program and to develop a team of committed and caring staff who provide holistic and compassionate services to clients. When something is working well, why change it?

Thank you very much for this opportunity to speak to you today. Marie Jean would like to add her comments now.

Mrs Marie Jean: Good morning. My name is Marie Jean and I have been a client of the support services program since January of this year.

The support services program at the P.R. Cook Apartments is unique. It has been planned to service the needs of aging tenants who no longer can do everything for themselves.

The support services staff are a group of people who are handpicked for their ability and capability of making people feel secure and safe. They can knock on your door in the morning to see how you are. If you need assistance of any kind, they are there to serve you. Support services have hired people who can be trusted. Activities are carried out by the staff to make the people happy and

comfortable in all aspects of life, such as making a bed, helping you with your breakfast, or activities such as crafts, exercises, amusements of all kinds.

1100

Having been a homemaker and a foster mother myself in my lifetime, I am now extremely happy to be on the receiving end of all this. The cost that I pay gives me control over the services that I receive. I do not approve of the support services program going into an umbrella-type management. I believe too much would be falling through the cracks. This type of service needs a hands-on manager or supervisor in order to see that all needs necessary are covered at all times. I thank you.

Mrs Yvonne O'Neill (Ottawa-Rideau): I wanted to ask a little bit more about the manner in which you've established the fee structure, and is there any means test, are there people in the residence who are on social assistance, or do people really have to be part of the middle class to become tenants and to get into this? It seems to be a wonderful program.

Ms Bowd: It is. No, our building is 50% subsidized rent—50% rent geared to income and 50% market rent. When we were setting the fees for our program, obviously we looked at the costs of the program, but we also looked at the income that the senior citizens we're serving have. So we very carefully assessed that income to ensure that they could afford to pay the fees. Don't forget also that they're only paying 30% of the cost of our program.

Our program fees range from \$82 a month to \$163 a month. The \$163 a month could be subsidized down to \$108 a month for people who are on the basic pension.

Mrs O'Neill: And the other 70% is paid by whom?

Ms Bowd: By the long-term care—Ministry of Health.

The Chair (Mr Charles Beer): I'll call on the next presenter, the Alzheimer Day Centre, St. Joseph's Heritage.

Mrs Sullivan: Mr Chair, while the next intervenor is coming forward, I wonder if I could ask the ministry to clarify: Is it the ministry's intention to designate every community health organization as a multiservice agency?

The Chair: Parliamentary assistant?

Mr Wessinger: I don't know whether I can answer that specifically. I don't know whether a policy adviser really can answer that question. I'm only aware of the Rainy River situation and I don't—Mr Quirt, can you clarify anything further?

Mr Quirt: Just to say that in the two cases in northern Ontario the ministry has taken that position because the comprehensive health organization is designed to allow for the coordinated delivery of a whole range of health care services to a designated population, and the long-term care percentage of expenditure would be probably somewhere around 10% of what the CHO budget would be for that group of individuals being served. In both cases in northern Ontario, the consensus was reached fairly easily that it would make sense for the CHO, if responsible for a range of health care services, to also be responsible for the MSA. The minister has certainly not

indicated to the few other areas planning CHOs that this is going to happen. I think there would no doubt be discussion locally to make sure that the same consensus was in existence in each community.

Mr Jackson: Mr Chairman, if I might, I didn't want to raise this as a point of order. I was going to wait until the end of this morning's segment, but the previous Chair bore witness to a line of questioning I gave to Mr Quirt in this area. Is he now suggesting that there are two health service organizations that have received similar approvals to that of Rainy River? And I'm still waiting to have you, Mr Quirt, explain to this committee which MSAs in this province have received formal or informal or quasi-approval or consideration. To date you've only said Metro Toronto, and we discover one while we land in the north and I now sense you're referring to a second one. When will we get this list?

Mr Quirt: Just to clarify, I indicated that the only submission made to the minister, from the DHC, on multiservice agencies formally had been the one from the Metro Toronto DHC.

Mr Jackson: Mr Quirt, if you check Hansard, I asked you, "Any informal approvals for MSAs?" That's what I asked, and I asked for it three times over the course of a week. I don't wish to be argumentative. I've asked a very clear, simple question: Which ones have received this form of informal—whether they were by a DHC or a CHO or whom?

Mr Quirt: My intention is to try to provide as accurate information as possible, and if I haven't done that I apologize. Once you read the Metro Toronto submission, you'll see that the submission was in effect—I checked with the minister in kind of midprogress. They were basically saying, "Minister, are we on the right track here?" The minister said, "Yes."

Mr Jackson: I'm sorry. Mr Chairman, on a point of order: We're in northern Ontario. I'm not asking about Toronto. He said there are two of these arrangements that were service organizations. Could I get the list, for the third time?

The Chair: So what you want to know is, is there a list of those that have either been formally designated—

Mr Jackson: He's implied there are two that have been approved. We were then able to discover one of them. What is the other one you've discovered?

The Chair: I wonder if there are others that can be named at this point, or we can come back at the conclusion of this morning, because I do want to get on to our next presenters.

Mr Quirt: Very briefly, there are no others that I'm aware of. I know that the minister has indicated formally to the Rainy River CHO that yes, it makes sense that the MSA be among the services that organization plans and delivers. I'm not sure whether she's given the same assurance or the same direction or confirmed with the Wawa CHO. I'll find that out and let you know.

Mr Jackson: Thank you.

ST JOSEPH'S HERITAGE, ALZHEIMER DAY CENTRE

The Chair: Welcome to the committee. If you would be good enough first just to introduce yourselves and then

please go ahead with your presentation, and we'll have 15 minutes from now.

Ms Frances Adderley: Good morning. My name is Frances Adderley, and for the past five and a half years I have been manager of the Alzheimer Day Centre of St Joseph's Heritage. The day centre was established in 1986 and is located in and administered by St Joseph's Heritage, Thunder Bay, Ontario. I was a member of the long-term care consultation committee and therefore have taken a keen interest in the long-term redirection legislation.

With me today is Elizabeth Montgomery. She cared for her elderly mother, who was a client at the Alzheimer Day Centre for one and a half years prior to her admission to Bethammi Nursing Home which, incidentally, is housed under the same roof as the centre. Liz's mother passed away earlier this year and Liz has graciously consented to accompany me here today and present her views. Thank you for providing us with this opportunity to express our feelings and concerns re Bill 173.

The Alzheimer Day Centre, which has been in operation for seven and a half years, is currently administered by St Joseph's Heritage but is funded by the Ministry of Community and Social Services. Our clients are people afflicted with Alzheimer disease or related dementia. Our mission statement, philosophy and values are based on those of St Joseph's Heritage.

The Alzheimer Day Centre not only provides excellent individualized care to each client who attends, but has a reach that extends into the community, serving as an educational resource for Confederation College and Lakehead University through field placements for nursing, recreational leadership, social work and gerontology students.

The staff networks in the community by serving on many community committees. We provide education and training to various community groups and agencies. The program manager has delivered 32 hours of training to these organizations in the past year.

The program manager is directly responsible to the executive director of St Joseph's Heritage and she meets six times per year with the Alzheimer committee, which is made up of volunteer board members, representatives of the Alzheimer Society, care givers and staff.

The Alzheimer Day Centre is at an advantage as it is housed in an existing long-term care facility where we can access the support services available at the Heritage. These services include dietary, accounting, payroll, housekeeping, maintenance, health nurse, health and safety inspections and fire inspections.

1110

We also have available to our clients the services of a hairdresser and a barber, a dentist, physiotherapy department, doctor's office, psychogeriatric consultant, a store, a chapel to meet the spiritual needs of our clients as well as a very beautiful therapeutic garden that was specifically designed for our Alzheimer clients.

We already meet the criteria which are spelled out in the draft copy of the adult day program manual that I recently received from the long-term care division of the

Ministry of Health. Why, then, would the ministry want to transfer an existing day program such as ours, with knowledgeable and experienced staff, to the jurisdiction of a multiservice agency? Why not allow the program to remain as a community-based program administered by St Joseph's Heritage?

The Sisters of St Joseph of Sault Ste Marie have a long history of providing excellent health care and meeting the needs of the people in the community. Their example of love, compassion, caring and community spirit has been ingrained in those who work in their health care facilities. Staff, volunteers and the general public chose to associate themselves with St Joseph's Heritage because of this.

I have worked in other health care facilities which lacked that rhythm or spirit that I find so unique in the Heritage. The staff are caught up in this spirit and are encouraged and are expected to maintain the high standards of quality of care that they provide to the people they serve.

Our volunteer board members give freely of their time because they are committed to the vision and the philosophy of St Joseph's Heritage. Five of these board members as well as other volunteers sit on the Alzheimer committee, which meets six times yearly. These people are dedicated and committed to ensuring that the Alzheimer Day Centre staff meet their goals and objectives in providing excellence in their service to those they serve.

I support Bill 173's assignment of a multiservice agency to provide simplified access, information and referral services related to long-term care and other community agencies. However, Bill 173's intent to change the administration of these support services to the multiservice agency and to establish one large board of management causes me great concern.

The public is aware of and will probably welcome this one-stop shopping approach to long-term care, but have they been told of the extent of this Bill 173? People do not like change, especially older people. Agencies such as the Alzheimer Day Centre, Red Cross and Victorian Order of Nurses are familiar to them, as many have already accessed their agencies at one time or another and they trust them. Will they feel the same way about the services, once transferred to the jurisdiction of the multiservice agency? I think not. People want choices. They want to stay with the familiar, and they will often shun the unfamiliar.

At the present time, there is much confusion and concern over Bill 173. There are rumours among health care professionals about job losses. My staff and I fear that even though together we have 25 years' experience dealing with the elderly, especially those with Alzheimer's disease, we may lose our jobs if the administration of our program goes under the multiservice agency. We fear that we may be forced to compete with those already displaced due to closure of beds in other health care facilities.

We also wonder whether the Alzheimer Day Centre will be housed in another facility if Bill 173 is passed. I personally left a higher salary position 15 years ago to come to work for St Joseph's Heritage simply because I

was drawn by the vision and philosophy of the Sisters of St Joseph.

I believe that given the level of confusion and the concern over this issue, the government must inform the public about what is really going on and how far the bill is going.

I want to thank you for allowing Liz and I this opportunity to share our thoughts and concerns regarding Bill 173. Liz will now tell you how she feels about this.

Ms Elizabeth Montgomery: I have been a care giver for three years, and my family member attended two different day care centres throughout that period of time. The first day centre was city-organized. It utilized an old public school basement room which was entered by two flights of stairs. Stacking wooden tables were stretched down the centre of the room and wooden stacking chairs surrounded them. One paid staff and one or two volunteers manned the centre. The agenda for the day was definitely not geared to memory-impaired clients, and the staff was not trained for their needs. My family member became very anxious and pleaded with me to stay home on her scheduled days. These times became very stressful for both of us.

The following year my family member was enrolled in the Alzheimer Day Centre. Their family-client support worker was very caring and helpful, as were all the staff there. My family member responded so wonderfully to the homey, warm atmosphere and the dedicated, loving staff. Each client was treated with respect and was a unique individual given every consideration. My family member learned to trust once again. The Sisters of St Joseph have a reputation for excellence when it comes to delivering optimum quality nursing care and efficient administration.

Now, I ask you, which day care facility would you consider for your loved family member? I urge you: Do not dismantle and destroy the philosophy of St Joseph's Heritage and the Alzheimer Day Centre of the Sisters of St Joseph. You cannot and must not move the heart and soul of St Joseph's Heritage to a multiservice agency. Thank you very much.

Mr Jim Wilson (Simcoe West): Thank you very much for your presentation. You ask what's going on, and perhaps the government should inform the public as to the extent of this legislation. I think, though, your presentation indicates that you've pretty well figured out what's going on. This is social engineering to its furthest degree, and yes, you will have to worry about your jobs, and you will have to worry about whether St Joseph's can continue with its philosophy and its approach to caring under a new bureaucratic MSA.

I do have to ask you, though, to date, how have the discussions been going in Thunder Bay and in the local area towards establishing an MSA? Can you give us a feel for what's going on here?

Ms Adderley: I have gone to different committees. We've been invited to a long-term care committee, also in the district health council. However, as a member of the long-term care consultation committee, I read every document that came across my desk, and all it was telling

the people was that it's going to be one-stop shopping and encouraged—I myself encouraged them. We had a group of elderly people going all through northwestern Ontario presenting a play on this. But nowhere did it say that it was going to tap in and take away all these agencies, like the day centre and the VON that are going to be under this one MSA, and that concerns me. Do the people really know the extent of it?

Mr Jim Wilson: You're right. What seems to have happened is the government put a peculiar twist. I mean, you're right, originally and what we heard from the public during the consultations was one-stop shopping, in particular one phone number so you didn't have to spend a day or two trying to figure out how to access services. That rather simple idea, by the time the government got hold of it, it also decided, for really ideological reasons, that the MSA should also deliver at least 80% of the services and after four years be delivering 100% of the services in the area. That's where we just have a fundamental disagreement, and I'm glad you've said that somehow things have gone awry from what was in the planning documents to what is actually in Bill 173.

Any idea why the government wants to now deliver all the services? Is there something wrong with the services you're delivering?

Ms Adderley: No. In fact, I think we do provide excellent services. All our evaluations, all our feedback from our clients, our care givers, from all the students, all the volunteers and all the public has been excellent. I think you would hear an outcry from these people to say: "Why, what are you doing? They're doing well. They're doing excellent care. Leave it alone."

The Chair: In terms of the equipment, I'm just asked if you would activate the mike when each member is going to speak. There are still some problems. Parliamentary assistant.

Mr Wessinger: Thank you very much for your presentation. What I'd be interested in knowing is, in particular with respect to the delivery of Alzheimer Day Centre-type services, do you feel that those types of services are best delivered through an existing long-term care facility? Do you feel that there are advantages to having that delivered in that manner as distinct from being an independent-type service?

1120

Ms Adderley: Yes, I think they'd have an advantage. We have a facility now that meets all the specifications that were in this manual that I just recently received. It had to be accessible. We have everything that anybody needs. It's very easily accessible. We have the use of all the maintenance. The manual states that the director of this day program would have to look after safety issues, that she would have to go and look after health inspections and that. Why would somebody highly qualified have to look after that when that's already being administered under the roof of St Joseph's Heritage?

I also feel that we know that by the year 2000 we're going to have an influx of the elderly generation. In fact, there's going to be a major outbreak of Alzheimer's disease because all these baby-boomers are aging. It's not

only a disease of the aging. When a 57-year-old lady who was very well looked upon in the community, very highly qualified, walks in and can't talk, that wrenches your heart. We know that St Joseph's Heritage can deliver an excellent program.

My fear is, if it gets to the multiservice agency, what is stopping them from saying, "Let's have a generic day centre; let's put the psychiatric day centre and the people with Alzheimer-related dementia together"? What's stopping them? They can say: "Funding is tight. Why don't we put it together?" Then we won't have any say. This way I really realize that we're dedicated to these people. We owe these people and their care givers this day centre that is run beautifully. I feel that if you have extra moneys, why not expand and enhance our program that is already available?

I recently had 12 people on my waiting list. I got back from vacation, and we started going through this waiting list. Four of these people are now in an acute care hospital because I didn't have room for them. Now, if we had a day centre with money for expansion, then these people would not be taking up all that money in an acute care centre; we could be helping them. They could be accessing this.

I really, truly believe that going with a multiservice agency for programs such as day centres is wrong. Let them stay with the one-access shopping, but leave the running of a day centre, the admission criteria, doing the referrals and that to us. We're the ones who are working with these people. We should know what's going on. We should be doing the intake, not the MSA, as is suggested in the draft manual of the adult day centres.

ST JOSEPH'S GENERAL HOSPITAL

The Chair: I call on Mr Carl White of the St Joseph's General Hospital. Welcome to the committee, Mr White.

Mr Carl White: My name is Carl White, and I'm the chief executive officer of St Joseph's General Hospital in Thunder Bay, Ontario. I think it's important to point out that it's St Joseph's General Hospital in Thunder Bay, Ontario, because, as you've heard in these hearings, we're a part of a large chain of health care facilities across this province and country, and we deliver health care with a particularly different bent, a philosophy that's different, that challenges what goes on out there in the community. That's sure been demonstrated today by the people who preceded me. It was wonderful to sit here and listen to them.

Our hospital provides a wide range of services, including many rehabilitation programs which are consumed by the client population for which Bill 173 was designed. I read with interest the content of the draft of Bill 173; at least I hope this is a draft form, if these public hearings are really put in place to hear the comments of both providers and consumers.

First, I would congratulate and to some degree support government initiatives to develop long-term care reform and make it easier for seniors and others to gain access to services. All of us in the business of delivering long-term care need to make access easier for the consumer,

provide needed services to keep people independent in the community—we're not in the business of bringing people in and putting them in hospital beds; we want to keep them in the community—and have all agencies work together to support the consumer.

If you look today at a patient who's in an acute care bed, we're working with other agencies and they're helping us get them out. We get tremendous support from home care in this community when we have to get somebody back to the community. Services are available. Interestingly enough, we don't have a bureaucracy controlling that; we make those arrangements, and we do it.

We have to maximize the amount of money spent on direct services. I think today you have to look at what's happening at the bedside and reduce the administrative and overhead costs as much as you can. Bureaucracy and overhead costs don't exactly translate into good patient care, good care in the community or good care at the bedside.

In reading the proposed Bill 173, I have two concerns related to the administrative arrangements. It would seem that the MSAs would create a new level of unnecessary administrative costs, a new bureaucracy. I'm concerned that the rule on the purchase of only 20% of services from outside the MSA will eliminate the use of many excellent support programs and eliminate many of the providers of those excellent support programs.

I'm always concerned when government attempts to create a new structure such as an MSA to broker services provided to the public by existing agencies that are governed by existing voluntary boards. I think the key is voluntary boards. There's a lot of free work that goes on out there in the health care system. Don't destroy that.

These boards represent the community and are in place to develop and have services made available to those needing them in the community. In fact, as I think about the history of health care in our country, in our province, I do not see much of a role for government in controlling service delivery. Government and district health councils should be concerned with broad social policy issues and direction. Long-term care is one of those things you have to congratulate and support. It puts a policy framework in place. Now people need to provide the services that are needed to address that policy framework.

Local and voluntary agencies should be responsible for direct care delivery and direct service delivery. This is now done, and done quite well, I might add, by voluntary non-profit organizations, which are in a position to meet the needs of the community and have done so for many years. There was health care and social policy care in existence in this province and in this country before governments intervened in it. This is one component of the Canadian health care system which makes us all proud: It is represented by the community and reacts to community needs.

I would suggest that services could be better coordinated through the use of existing agencies and government structures. Just look at the experience we have with placement coordination services. They'll be replaced by MSAs under this bill, the way I read it.

At present, our hospital and many other acute care hospitals deliver a wide range of services to support the elderly. Take the time to walk through a few hospital wards. You will find many seniors receiving care.

We have been creative in acquiring new programs and in redirecting existing funding to support the elderly population. This has been possible because we are aware of the change in the marketplace and are astute enough to meet the needs of our customers. This comes from responsive administration and responsible governance.

Some of the programs in our hospital—and this is just an example in our own hospital in this community—which support the elderly population are medical day care, which was funded by reducing inpatient beds and redirecting funds; psychiatric day care, which was funded in the same manner; special rehabilitation clinics; a reactivation unit, which was funded and put in place reallocating acute care funds; Meals on Wheels, a partnership with a community agency; a large addictions program, which for the most part was funded by redirecting inpatient funds; a quick-response team, from the allocation of our own resources.

Incidentally, we had a quick-response team in a partnership with VON home care in this community about two years before the government thought it was in vogue and put extra funding out there to fund them. I think they could have been done with a reallocation of dollars, but don't cut us off from any cheques for extra funding. The hospice unit was done with the reallocation of funds in our own hospital.

1130

When you see agencies in a community redirecting funds, that really demonstrates a responsiveness to community needs. You don't always become popular with the people in your own organization when you do that, because it's change, and change upsets people, but we've been able to do that.

Our boards have recognized the need for these programs and have supported their development. Be careful when you impose new legislation. Don't destroy the components of the health care system which were developed through the direction of our volunteer board members.

Will Bill 173 allow for a bureaucracy such as the MSA to take over these programs? Will additional government control encourage people to meet community needs? I don't think so.

I have always been proud to work in health care because we've been able to hear the community and make changes to meet its needs. This has been accomplished by allowing voluntary boards—and I stress "voluntary" boards; a lot of free time goes into this—to be creative and to work in the direction needed by our community.

Quite frankly, I don't think additional government control, which I see in Bill 173, will improve the system. I, for one, don't want to work in a centrally controlled environment which begins to resemble a police state. That's not the kind of country or province we live in. I urge you to create enabling legislation to preserve the

creativity and strong desire of our agencies to meet the needs of the communities we serve.

The Chair: Thank you very much for your submission. We have time for a question from each caucus.

Mr Martin: Thank you very much for your presentation. Obviously, you and so many others who deliver health care to the citizens of this province do a wonderful job. I don't believe what you do in the hospital sector will be affected tremendously by this particular piece of legislation.

However, you do make some comments that ask me to ask some questions regarding what it is that we're doing here that causes you to make a statement such as, you know, not wanting to live in a police state. Certainly, what this legislation is about is trying to provide greater access and equity across the province. I come from northern Ontario, as you do. As a member of this government, what I'm trying to do is get as much service out to the people of my area as I possibly can, particularly to the smaller remote areas which, up to this point, have not been privileged to receive some of the services that we who live in the larger centres take for granted.

The group before you presented, as well, a wonderful program that is offered through a wonderful organization here in Thunder Bay that the rest of us in northern Ontario would love to access, although I must say that it's probably not the only organization offering very good services.

I guess the question I have, and it goes back to a thread that I keep being hooked on as we go through these hearings, is this whole question of, will people continue to be concerned about people if we change the format so that services to the elderly are being delivered by a more community-based, community-wide organization than the specific ones that are out there now, and will the people who came forward with the groups who presented before you, as volunteers, continue to want to volunteer on behalf of their neighbours and their families if there's another organization in place delivering that service, or will they just walk away from it?

Mr White: I think organizations in communities are able to bring together volunteers because volunteers identify with specific organizations and maybe the specific value or the specific belief of that organization, or they go there because unfortunately someone in their family has been afflicted by a certain condition that brings them to that organization. I think that what you have there is a great degree of organizational identity and pride in the community, regardless of which organization it is.

I volunteer to do certain things in the community on my own time, which I won't bore you with, but I do it because I have an interest in those areas and I'm proud of what those organizations do. That's what the diversity of the organizations we have does in this community. I think when you put together one large bureaucracy to control all the organizations, what you do is lose the identity of the specific organization. So you have to be careful with that. I think that's the bad side of Bill 173.

The good side of Bill 173 has to be that someone takes and coordinates all those organizations so that when I'm

looking for a service for my mother, I can phone one number. That's how this bill was sold, but that's not how the legislation works.

If you look at the placement coordination services in Thunder Bay that coordinate the placement of people in the institutional sector, they're run by a voluntary board, and it coordinates the efforts and the pride and the good job that a lot of other voluntary boards do in getting people into the right accommodation. That can be easily transposed to the whole MSA model. You don't have to blow up what's there and hire people to do it and add cost to the system. Cost to the system doesn't do anything to provide care to the people.

I for one, in my personal life, would not volunteer to work in an organization that did away with all that identity and pride that exists in my community. That's what makes me proud to be part of my community. You see, you have to understand that. You can't bureaucratize the good things in the community and expect people to keep coming to help you. They'll go and work in some other sector as a volunteer. Volunteers always volunteer to do something. So don't turn them away with the legislation in Bill 173.

I'll tell you the one place people don't volunteer. They don't quite always get out and volunteer to work for government agencies, and that's what Bill 173 appears to create to me. I don't go and volunteer and work for a ministry of somebody in a government, but I'll go work for many social and health care agencies as a volunteer. I'll give much of my time, and I do.

Mrs O'Neill: Mr White, you're showing us some of the spirit of the north.

Mr White: You betcha. That we've got.

Mrs O'Neill: I found the presentation very interesting. I want you to know before I begin my question that we are certainly going to introduce an amendment regarding the 20% capping of the buying of services.

You, I think more than anyone to this point, have highlighted voluntary boards or volunteers serving on boards and the reallocation of funding that's possible with that kind of governance structure. I think that certainly shows that things can work in many ways the way they are now. Because you've brought it forward, as have two other presenters this morning, I wanted to ask the parliamentary assistant what he could tell us regarding the relationship between the governance structures of the DHC, the MSA and the facilities' governing bodies. Is there a relationship worked out at the present time regarding those structures? It's very fundamental. People do have a right to know how they are going to have their decisions made, what kind of governance they can expect as a result of Bill 173; DHC, MSA, facilities' governing body relationships, please.

Mr Wessenger: I will ask Mr Quirt to answer that.

Mr White: It's not in that bill.

Mr Quirt: If I could run through the three groups that have been mentioned: the DHC, the MSA and facilities. The district health council's role continues to be an advisory role to the Minister of Health. With respect to long-term care, the DHC has been asked to give advice

to both the Minister of Health and the Minister of Community and Social Services on what long-term care programs should be in each community and to what extent the government should support them. So, DHCs would be submitting plans to both ministers, making recommendations. In other words, the DHC would provide advice to the minister on how many community service programs should exist, what their boundaries should be and how much their budgets should be; advice and recommendations to the minister developed by the long-term care planning committee and provided through the DHC to the minister.

The DHC would be saying, "Minister, we think you should fund three MSAs in this area, five supportive housing programs"—and probably including the one that your organization operates—"perhaps two or three attendant care outreach programs and conceivably some independent day care programs." The minister's job is then to take that advice and make decisions about to what extent she wishes to support each of those organizations to deliver long-term care and, through her staff in the long-term care division, negotiate budgets with each of the organizations to provide that.

The responsibility of the board of the multiservice agency would be very similar to the responsibilities of the board of your organizations or any other transfer payment organizations. In other words, you would contract with the government, receive funding to deliver a range of programs and your board is responsible for establishing a direction and policies to govern the hospital and the supportive housing program and the Alzheimer's day program and so on; I know you have different boards that do that. The board of the MSA would be responsible for organizing the delivery of the range of services that the MSA would provide, primarily in-home support services and volunteer-based services, as you're aware.

1140

The boards of long-term care facilities would continue to have a direct relationship with the minister through staff of the long-term care division. In other words, they'd continue to have a service contract with the province that would stipulate, from the provincial point of view, how much money was going to be provided and lay out conditions that the facility board would have to adhere to and, from the point of view of the long-term care facility board, they would commit to following program standards and so on, in return for that. They would then go ahead and fulfil that contract by managing the operation of their long-term care facility, setting the policies and monitoring its operation and providing general stewardship and providing direction to a key staff person who would manage the day-to-day activities.

In summary, the DHC role is to develop general plans for health care services and long-term care services in the area; make recommendations to the minister, saying, "Minister, this is the kind of system we'd like. Here are the agencies we recommend you fund and, in addition, Minister, we recommend you give them this much money"; the minister then decides. She may decide, nine times out of 10, "Boy, that's good advice and the community's really influenced my decision here," or she may,

in unusual circumstances, say: "Sorry, I can't follow that advice. It doesn't follow the policy of my government. I'm going to make a slightly different decision," and explain why.

But her job then is to fund the system and the MSA boards and facility boards and hospital boards and other boards funded by government, responsible for the overall stewardship of the activities of their organization, setting its general direction and policy and ensuring that the staff fulfil that mandate.

The Chair: We have a real time crunch. I'm going to permit Mr White to make a comment, but I'm afraid we're then going to have to move on. We have another witness and, because of the schedule today in Thunder Bay and plane arrangements at the end, we're just going to have to move on, so if you'd like to just have a question or comment.

Mr White: Just as a point of clarification: I haven't gone over my time so I certainly appreciate a chance to respond. I think your analogy of how things go sounds very good, but what you're saying to us in this committee is not what I interpret in the bill. Now, maybe because I'm from the north and I'm a French Canadian, I read the bill a little differently than you do. But you tell me there's going to be an agency put in place that's going to deliver 80% of the programs out there in the community; then you're telling me that 20% of the programs that are out there that are run by good volunteers—and they're good programs—are going to stay and 80% are going to go.

Now, along with your explanation, if you could give me a list of which ones of the 80% are going to, then maybe I'd have something to debate a little more clearly with you. But this 80-20 rule indicates to me that the governance and the responsibility for those programs will become part of a government bureaucracy—and I've already made my point in relation to that—and that 20% will remain. I think you need to really look at the wording of the bill, if the analogy you make in the relationship between government and DHC and governance structures is correct.

Mr Jim Wilson: Mr Chairman, can I just add there that I think the witness is correct and we also want to keep in mind that it's actually 100% after four years. The 80-20 rule is even gone.

Mr White: That's right. So there are no more independent boards.

Mr Wessenger: That's incorrect, too.

Mrs Sullivan: Could I have a point of order, please, Mr Chairman?

The Chair: The parliamentary assistant and then Ms Sullivan and then we really do have to move on. The parliamentary assistant first.

Mr Wessenger: I'd just like to indicate, to make it clear, that the board of a multiservice agency is an independent board. It's created by the community. It's not part of a government agency.

The Chair: On a point of order, Ms Sullivan.

Mrs Sullivan: Yes, I want to be certain that the record reads appropriately. Mr Quirt has indicated that

the MSAs will be responsible for arranging delivery. In fact, if that's what the MSAs were responsible for, people wouldn't be quite as unhappy as they are. The bill requires the MSA to deliver and when the witness indicates that his view is that 20% of services will stay with existing agencies, don't forget that that 20% of services can only be purchased (a) with ministerial approval, ie, the minister has to say yes, and that will also include services above and beyond the basket of services that is required that's mandatory and may include highly specialized services. So if you think that home care services and respite services that are delivered now by existing agencies will continue to be delivered by them even at the 20% level, then you're under a misapprehension. Agencies will be out of business that are in that business today. This is wrong.

The Chair: I'm sorry that time has become the enemy, but thank you very much for coming before the committee.

ASSOCIATION OF ONTARIO PHYSICIANS
AND DENTISTS IN PUBLIC SERVICE,
THUNDER BAY REGION

The Chair: I call on the representative from the Association of Ontario Physicians and Dentists in Public Service, Thunder Bay region, Dr Ruth Kajander. Have I pronounced that correctly?

Dr Ruth Kajander: Yes.

The Chair: Doctor, welcome to the committee, and please go ahead with your presentation.

Dr Kajander: Thank you, Mr Chairman, ladies and gentlemen. I am here on behalf of the northwestern section of the Association of Ontario Physicians and Dentists in Public Service, which essentially is the medical staff of the 10 provincial member hospitals.

We welcome the opportunity to comment on this bill, An Act respecting Long-Term Care, from the perspective of northwestern Ontario. We would like to offer some views on this bill from the front-line medical staff caring for the severely mentally ill, and by clinical staff I'm including the other helping professions and in particular our nursing staff, who are the cornerstone of the work with the severely mentally ill.

We're here because the severely mentally ill often cannot speak for themselves, suffering most often from schizophrenia, manic-depressive disorders, Alzheimer's and other disorders.

Bill 173 specifically refers to the elderly and physically challenged and makes no mention of the severely mentally ill, who by the nature of the illness require long-term care.

Schizophrenia, which is the mental illness par excellence, often starts in late teenage, early adulthood and is a lifelong condition and can have a very varied course. We have patients who recover quite well from the first bout and manage reasonably well. They may have further episodes and if they have episodic mental illness there is a tendency to become more and more disabled with each episode and requiring more and more community care.

We have catastrophic courses where a patient from the very first overt mental illness remains so impaired that

they will need lifelong long-term care.

You also have the geriatric population but the geriatric population is a very mixed group. You have the ones who are physically handicapped and becoming more so as they become older, and you have the ones who are primarily demented, and Alzheimer is one form, who will become confused, and in your over-85 age group a third of the patients are quite demented. You have psychological consequences of these changes and you also have the mentally ill who have been mentally ill off and on or continuously over a lifetime who then develop the problems of old age. It is very difficult to accommodate these patients in the old-age homes or the nursing homes or at home.

1150

Northwestern Ontario is unique. Given the distance and the sparse population, health care is more expensive due to the fact that often longer hospital stays are necessary and conditions that are looked after on an outpatient basis for a local patient could not be done for someone from Kenora and other places. The province absorbs the travel costs. Ambulances are extremely expensive. We also have the problem of declining grain shipments and problems with the seaway, the decline of pulp and paper, and younger people have to find jobs elsewhere, leading to an overaging of the population.

The average for Canada is 10% of the population over 65; we have 13%; and 3% does not sound much, but if you put it into absolute figures, it is for Thunder Bay 3,300 more people over 65 than the average of Canada. That, ladies and gentlemen, is a very large group, many of whom need long-term care beginning at various ages for various reasons.

We also know that this group, in general, even if they are still quite functioning, consume more health dollars directly than the population as a whole, and the indirect costs of special housing and support services.

The Lakehead Psychiatric Hospital has 70 psychogeriatric beds, 10 of which are already slated for closure by the end of September of this year, and the rest are in fact threatened with closure. Before a patient gets to it, we have a psychogeriatric team of a physician and a nurse with resources to all other health professions to visit a patient, to interview the family, the staff that's caring for it, trying to figure out how this patient could best be looked after, and this patient would not be admitted to the Lakehead Psychiatric Hospital unless there was really no other space.

The problem with this dual-diagnosed patient population is really the interaction of physical factors and the psychiatric factors, and this is becoming an increasingly difficult area for physicians because with all the modern medications we have, the interaction of these medications becomes a sign in itself, and we are for ever jiggling medication, coping with side effects, trying to figure out what medication does what, and some of the side effects undo the good effects we want from other drugs, and it's a very specialized group of nurses, of RNAs, of physicians and psychiatrists that work together to look after this very difficult population.

In the psychiatric hospital we also have 36 acute care hospital beds and another 36 rehab beds, which are by and large the chronic mentally ill population, and again, closures are in the offing. Our budget has been cut by \$5.5 million, and it is very hard to see how this population will be looked after.

As Mr White had already indicated, we have a very wide range of services. I don't quite know how we ever managed without psychiatric day care and medical day care at St Joseph's hospital, and especially the medical day care has in fact been an excellent babysitting service for patients who can't be left alone at home and are not infrequently brought to the hospital in the morning by members of the family where they are looked after and more than just babysat. These people are cared for. They have their dinner. They have their health care looked after. They might get physio. They might get other rehabilitative services. They have their shower.

It is hardly surprising that we have this very multifaceted collection of services that have gradually grown, and grown up with a good deal of volunteer initiative and flexibility, because we're also dealing with a very multifaceted group of sufferers, and sufferers is what "patients" means, to go back to the Latin root.

I would like to remind you that any change to the system may have unexpected consequences and any change has to be approached in a very gingerly fashion. A recent example for us is the closure of the northwestern regional centre. This centre looked after severely mentally handicapped people who, by and large, are brain-damaged people, either due to genetic factors, intrauterine or perinatal factors, and they had very poor functioning skills. It was decided that this group of patients should be looked after in the community and they're now in group homes.

The very experienced nursing staff we had and the RNA staff were, on the whole, not rehired. None of the nurses were hired for the group homes and we have now in these group homes these patients who adjust only with difficulty to change and who not infrequently have difficulty functioning in the more intimate atmosphere of a small group. An institutional setting can be more impersonal and easier for these patients who are easily overstimulated.

The staff was not as experienced, with the result that many of these patients now surface in the emergencies of the three general hospitals, who have no idea what to do with them, where they create problems, where there's no expertise to help them. They turn up at our emergency department of the Lakehead Psychiatric Hospital, and in outpatient, where I am working, we are spending a good deal of time trying to help staff and trying to help patients to deal with the problems. Our nursing staff goes out and visits, trying to be of support. Obviously, a large amount of direct health care is generated that was not used prior to their being placed into the community, and these are things that have to be thought out. Good intentions may backfire somewhere else.

I think we have to be extremely careful, believing that with a new set of bureaucracy some of the existing problems can be solved. We must remember that the most

beautifully designed, well-functioning system, even with unlimited funds, cannot prevent or cure severe mental illnesses such as manic-depressive disorders, schizophrenia or various forms of dementia.

For the chronic patient needing long-term care, rehabilitation often sounds better on paper than it is in practice. There is a conundrum of personal choice, safety and society's tolerance, individual freedom versus social control. Long-term care will not infrequently be an unhappy compromise between what society can provide in the widest sense and what the individual may want, even if the individual is totally competent; in many cases they are not, which creates other problems.

In closing, I would like to thank you for listening to my comments.

1200

Mrs Sullivan: You've raised a matter that is, I think, of very serious concern to all of us on the committee. There's no question that mental health reform initiatives have apparently been delinked from long-term care reform initiatives and I think that's the basis of the problem. I think that this is not also a new problem but one that has to be faced.

You talk about the dually diagnosed, and many of those people in fact are cared for in long-term care facilities, although some use community services. One of the things that concerns me about this bill is, first of all, we've been told that the psychiatric and other mental health services are not being contemplated in this bill, but as well for those people who do require those services, the only assurance to the patient or client which is given in this bill is that they will be put on a waiting list. There's no assurance of the timeliness of the specialty training in terms of, even in the intake process, in the assessment process, identifying some of those difficulties which may exist nor a continuity of services. I wonder if you would just comment on those gaps that we see in this bill.

Dr Kajander: In part, of course, this is why I am here, because these are the gaps we see and any separation of the mentally ill from other long-term patients is purely artificial because there is a constant overlap and people are shifted from one system to the other system and during a lifetime may have different needs. We are saying, in order to improve on the present situation, it would have to be a far more comprehensive system.

In fact, as Mr White said, in the Lakehead, which in a way is a testing ground, because essentially we are a closed community, somehow this community has to cope with the problems, and we have, in creating different services that do work together. While we would certainly welcome any improvement, I try to caution against certain quick changes, because these are very delicate systems where people have learned to work together, rely on each other, trying to look at the whole picture and see how we can fit in a patient.

You see, the thing that has worried many of us about the mental reform bill is the attempt of finding a bureaucratic solution for a multitude of problems. There's far too much hope that if you have enough pigeonholes,

everybody will fit in. In psychiatry, in health problems, that doesn't always work because we are working with too many different problems, with too many individual problems that need a far more flexible, individual approach.

Mr Jim Wilson: Thank you, Dr Kajander, for making us sensitive to the needs of the mentally ill; particularly you mention schizophrenia and those with dementia and then the problems with old age. I just want to pick your brain for a second with respect to the bed closures at Lakehead Psychiatric. Are the community-based services in place now to catch those people who are being deinstitutionalized? Because all three political parties over the last 15 years have been guilty of deinstitutionalizing people without having the services in place. So how are you coping with those bed closures now and what do you see in the future when there's an MSA in place?

Dr Kajander: Well, the overwhelming mood is one of despair and seeing a nightmare, because as far as we are concerned, the community services are not in place and, for many of them, we don't even see how they could be put in place, because many of the chronic mentally ill may show explosive behaviour and may show sudden emergencies, and I don't see how you can do that in a group home with one or two staff.

If we have a sudden behavioural disturbance in the Lakehead Psychiatric Hospital, we pull staff. We call a code and everyone who is not needed that particular moment, meaning particularly the nursing staff and RNAs, will immediately come to that ward and be of assistance. Now, I, for the life of me, cannot see how you could staff community homes for patients who may present sudden emergencies.

Mr O'Connor: An earlier presentation we had from St Joseph's General Hospital, in the brief he had talked about the PCS, and I guess when we came here in the last round of hearings, we heard from so many of the people in the community here how wonderful the PCS was and how well—

Dr Kajander: What is the PCS?

Mr O'Connor: Placement Coordination Service—for the facility here, and how wonderful it was and the problem was is that not every community had it, and so Bill 101 ensured that everybody in the province was going to get some service that the people here had. So it was important. One thing that we keep hearing is that this is going to create a bureaucracy now by moving forward in providing care for people that isn't the same in every community today, just like PCS wasn't a reality in every community. So what we're trying to do is not dismantle all the good that's out there, but work with all the groups that are out there presently, set up a local advisory board, one that's going to work with the community.

The question I actually have, and I'd like maybe a ministry official to respond to it, to perhaps give you some sense of where the direction it's being taken, because we've heard from the Alzheimer presentation that they're concerned about the services they provide and how they fit into day care programming and what not, and the fact is that there's an Ontario association that's been involved in the working group, and I want to know

whether or not from a ministry official the same type of involvement is then going to take care of long-term care as it fits into some of the mental health needs within a community in some of the local planning, and how their dovetailing will work.

Mr Quirt: Certainly one of the ways in which there can be a close connection between the planning that is now going on for improving long-term care services for the generic population, and the planning that has begun to look at the specific needs of the client group who need mental health services in the community, one of the ways in which those two things can be interrelated is at the district health council level, and certainly district health councils have come to us and noted the natural kind of connection in planning and the connection that's possible at the community level in meeting those needs. I would point out that a very large percentage of our clients in long-term care facilities, some would suggest greater than a third of our clients, have some degree of cognitive impairment, and I know that is a logical kind of connection there between the mental health system and the long-term care system.

Certainly, our long-term care system serves clients in the community with a variety of different health problems, including mental health problems. For example, our VON nurses visit people who are in group homes that have been established to help them deal with their mental health needs. We certainly visit group homes that have been established to help people with developmental handicaps stay in the community. I know that the long-term care division is represented within the Ministry of Health on mental health reform in the person of my director of policy, Dr Patrick Laverty, and I think there are ways in which the system can be more closely integrated over time. Our bill, for example, does not preclude the notion of a multiservice agency adding to its range of services, services that are specific to the needs of people who need mental health services in the community.

Mr O'Connor: The planning will still take place at the district health council level and not—the MSA isn't to do the planning. The planning is to be done by the district health council.

Mr Quirt: The MSA's role in planning is simply like any other transfer payment agency, to plan how best to deliver the range of services it offers, like a hospital or a children's aid society or a home support program now. The planning for the health care system and for the long-term care system and for the community mental health system is the responsibility of district health councils.

The Chair: Doctor, would you like to make any final comment on those comments?

Dr Kajander: Not really, unless you have any other questions.

The Chair: Thank you very much, then, for coming before the committee this morning. We appreciate it.

Mrs O'Neill: Mr Chairman, can I have one point of clarification?

The Chair: One point of clarification from Ms O'Neill.

Mrs O'Neill: What Mr Quirt has just stated is not

exactly what I remember from the briefing on Thursday in Hamilton as far as eligibility criteria. So are we hearing now that eligibility criteria of the MSA, at the direction of the DHC, may change over time? This is very fundamental regarding mental health.

Mr Quirt: I'll try to respond briefly to that. The eligibility criteria for the MSA, in determining what kind of services to deliver to the people in the community, the MSA would be required to take into account what other programs and services or supports the client had in his or her normal living situation.

For example, if we were providing visiting nursing to a family where there were a number of teenagers living at home, then the prospect of the government or the MSA providing free homemaking would be less. The MSA would say, "Gee, you really don't need help with doing the dishes and so on because your kids are adequately looking after that need."

Or, for example, if a client who lived in a group home for developmentally handicapped people who had moved from a facility for developmentally handicapped people were to contact the MSA, the MSA wouldn't send in a homemaker because the Ministry of Community and Social Services funding is already providing for developmental service workers in that facility who are helping those clients learn the skills necessary for independent living. But if that client in the group home required a physiotherapist or a speech therapist, then they're as eligible as anybody else is for a service from the MSA because that service isn't provided normally.

Or if I, for example, lived in Sutton Place Hotel and called the MSA for a homemaker, they would say: "Gee, you've already paid for that. When you pay your bill for your room, there are people who come and clean your room so we're not going to do that. But we'd be happy to send you a nurse."

Mrs O'Neill: Mr Chair, my question was directly on mental health. I wasn't the least bit interested in home-making. I think I understand that. But the eligibility criteria were pretty clear on Friday. Now I want to have it clarified. This is a very fundamental part of this spinoff of this bill.

Mr Quirt: I'm going to have to ask for an opportunity to discuss it with you later, because I'm not sure what I haven't covered. If someone is living in the community with a mental health need and needs assistance with homemaking or with remaining independent, then the supports like nursing and homemaking and so on they are eligible for from the MSA. The MSA won't have psychiatrists or mental health counsellors there to meet the mental health needs, and that's a legitimate criticism for people to make of the bill, that it doesn't cover off for that need. But in terms of someone with any type of disability living in the community needing support to maintain your independence in terms of the activities of daily living and needing the kind of things listed in the bill, it doesn't matter whether you need them because you have a heart condition, because you have Alzheimer's, because you have schizophrenia or because you have diabetes. If you need them, they're available to you.

The Chair: If I could, just before closing, remind

everyone if they would check out before 1 pm. The time parameters this afternoon with planes and so on is tight. We will need to begin at 2 sharp because we must end at 4 sharp, and I'd appreciate everybody's assistance in that regard.

With that, we stand adjourned until 2 pm.

The committee recessed from 1215 to 1400.

The Chair: Good afternoon, ladies and gentlemen. I call the standing committee on social development to order. We begin our afternoon session in Thunder Bay, and we're discussing Bill 173, the Long-Term Care Act.

VICTORIAN ORDER OF NURSES,
THUNDER BAY AND DISTRICT BRANCH

The Chair: Our first witnesses this afternoon are representatives from the Victorian Order of Nurses, Thunder Bay and District Branch. I would invite them to come forward and, as you do so, welcome you to the committee. Once you're settled and have poured some good Thunder Bay water, if you would just introduce yourselves and then please proceed with your presentation. We have a copy of your submission as well.

Mrs Harriet Laudadio: I'm Harriet Laudadio, executive director of the Victorian Order of Nurses, and accompanying me today is Donna Opie, the director of the home care program.

The Victorian Order of Nurses of Canada is a national, not-for-profit voluntary health care organization. VON understands the need to put caring first: caring through all stages of life and for the best quality of life.

The Thunder Bay and District Branch of the Victorian Order of Nurses has been in existence since 1898. We are located at 405 West Isabella Street in the city of Thunder Bay, with several satellites in the district ranging 350 miles.

Our volunteer board of directors brings expertise, specific skills and commitment to our branch. They represent various community groups and serve as board members because of an interest and a desire to serve the community. The responsibilities of the board are financial and strategic planning as well as policy development.

Our philosophy states that, "All Canadians have the right to comprehensive and compassionate health care and to participate in their health care." The goal of VON services is to promote health and independence and to enable people to live in comfort and with dignity in their home and community.

We continually develop new programs and services to meet the needs of the residents in Thunder Bay and district. We have administered the home care program since its introduction to our community in 1969. We not only share the same physical location, but we also are governed by the same board of directors and utilize the services of the same business manager, receptionist and confidential secretary. Our nursing department offers the visiting nursing program, foot care clinics, the VON adult day centre, occupational health, the school medication program and paramedical assessments. Areas covered by VON nursing are Thunder Bay, Pass Lake and Kakabeka Falls, Manitouwadge, Marathon and Heron Bay.

Mrs Donna Opie: Our home care department offers

the home health care and the acute and long-term care programs, the integrated homemaker program and the school health support services program. We have submitted to you a list of several communities throughout the Thunder Bay district in which we provide service. This is not an all-inclusive package. We service any client where we're able to procure the human resources in order to do so.

Through collaboration of our internal departments with other agencies, facilities and providers, we have developed and implemented specialized programs for particular client groups according to their needs. Some examples are the quick response program, mother and child support, the anti-nausea program, not for admission, palliative care, extended care for fragile individuals and reactivation programs.

VON and home care support the Long-Term Care Act's purposes and general direction. We can support simplified access, a consumer-focused system and greater flexibility in service criteria and delivery.

Our historical involvement in this community, however, necessitates that we speak to you today regarding the implications that Bill 173 will have on our health care system and our community as a whole. The concerns we will be addressing are: absence of case managers, exclusion of physicians, lack of acute care focus, protection of current staff jobs, loss of volunteers, dissolution of boards of directors and education and skill loss.

The case manager is not mentioned in the long-term care legislation. Section 20, dealing with the development of a plan of service and the revision of the plan of service, discusses one of the major case management roles in today's operations. Who will be doing this role in the new MSA?

The government should recognize the skill and the expertise of these professionals, the case managers, in assisting the client in identifying service needs. Understanding family systems, being knowledgeable about service provider roles and the availability of the service providers in their specific community, as well as coordinating the care for some individuals on our case load, is imperative. In many cases, the clients we are involved with today have more complex needs, are more acutely ill and require the services of both health and social disciplines. These clients often need someone who is able to see the whole picture and to orchestrate the participation of these external care givers and to share the pertinent information in order to meet the goals of the individual and his family.

The exclusion of the physician as a member of the interdisciplinary team is also evident. One of the stated purposes of this act is "to improve the quality of community services and to promote the health and wellbeing of persons requiring such services." The physician is an integral member of the health care team and cannot be excluded from participating in this process and in development of the service plan.

Lack of acute care focus: A key consideration in future planning regarding the MSA is the inclusion of acute or short-term care. The administrative-organizational implications of this integration are significant. The current

fiscal climate in the health care system as a whole, and the acute care facilities in particular, necessitates that an efficient, cooperative relationship between our two components be sustained.

In Thunder Bay and district, there are approximately 6,000 clients per year utilizing our acute care and support services. The relationship of the proposed multiservice agency will be linked to the hospital. Ultimately, the consumer will be impacted by service delays and waiting lists if organizational process impedes our effective communication process.

Mrs Laudadio: Protection of current staff jobs: VON has requested from the ministry protection for our union and non-union staff. If organizations are going to lose their identities, VON and home care strongly believe that the government should protect current home care workers', VON workers' and provider agency workers' employment.

Our staff is concerned about the displaced hospital personnel replacing the community personnel in this new multiservice agency, as was committed by the Minister of Health during the social contract negotiations. The government must recognize the expertise and commitments of the present community workers and guarantee them first option of future positions.

Loss of volunteers: This government states that as the MSA unites existing services and provider agencies, it will affect volunteers and staff of those agencies. It recognizes that fairness to workers and encouragement for continued volunteer involvement are essential throughout this period of change and MSA development. What happens after to these volunteers?

Volunteers are an integral part of many organizations in our community. They give hours of unpaid time, expertise and dedication. The value of not only VON's volunteers but all the volunteers who augment our services in the community should be recognized.

Is the government aware of the number of volunteers in Ontario participating in serving the health and social needs of the individual? Is the government aware of the number of donated hours of time these people contribute across Ontario? Have there been any inquiries across the province as to whether these individuals would be willing to volunteer for a large MSA? If the answer is no, this will have major ramifications for our community both financially and emotionally.

Dissolution of boards of directors: "Each MSA will be a non-profit incorporated entity operating at arm's length from the provincial government. It will be governed by a single board of directors."

This legislation forces the dissolution of community boards. VON is concerned about the loss of the individual boards from the organizations in our community. These individuals have donated their time, dedicated interest and expertise over the years. People volunteer for a board because of a genuine interest in the philosophy and values of a particular organization. As well, the size and composition of the board of the organization meets their individual comfort needs. Is there a role for these individuals on the large, bureaucratic MSA board? Finally, it is

an unrealistic expectation for individuals to donate the amount of time required to direct a large multiservice agency without some method of financial compensation.

Education and skill loss: The Registered Nurses' Association of Ontario stated that there are 5,000 unemployed nurses in Ontario who are educated and skilled. The legislation refers to educating the unskilled worker to work in the community. Why are we training new workers when we have the expertise of 5,000 unemployed nurses? Our cases are more complex, more challenging and require more technological skills than we have seen in the past, and the expectation is that the nurse can be replaced with a less skilled worker. Deprofessionalization may create losers, and in this case the loser could be the consumer, and it may also interfere with reaching the goal of quality care.

1410

Secondly, our national organization, VON Canada, drives our standards and procedures as well as participating in research. This has to be promoted. With the possible destruction of our provincial body, VON Ontario, we will lose the expertise and equality of standards across Ontario. Collaboration and sharing through the current organization ensures equity throughout the provinces. VON has historically been the leader in community nursing. We are good at what we do. Our local branch has proven to be efficient and cost-effective. What guarantees do we have that this will continue?

As representatives of the Victorian Order of Nurses, Thunder Bay and District Branch, we submit the following recommendations be considered when accepting the Long-Term Care Act, Bill 173:

- (1) Acceptance of flexible models stressing partnering of agencies as opposed to devouring agencies, their staff and their volunteer component;
- (2) A system-wide database be developed to eliminate duplication and promote ease of information sharing;
- (3) The inclusion of all members of the multi-disciplinary team.
- (4) The jobs of current staff of community agencies be protected; and
- (5) A strong communication plan be developed educating consumers regarding realistic expectations of the capabilities of this system.

VON believes that the valuable skills and experience of all community-based agencies which for many years made significant contributions to the community should be recognized and respected.

In summary, we believe that by partnering we can achieve the redirection goals without destroying the solid foundation already in place.

Thank you for giving us this opportunity to present.

Mr Jackson: Thank you for an excellent brief. You've provided additional focus on what have already been some outstanding briefs from VON in other parts of the province.

I wanted to focus a question with respect to the possible dissolution of your chapter and/or your provincial parent organization. My question might best be

directed to legal counsel, because my understanding is that in any charitable non-profit corporation that issues tax receipts and whatever and conducts itself in that manner, upon its dissolution very clear guidelines have to be followed with respect to the disposition of assets and where they can be transferred to. I wonder if there's anything in this legislation that legal counsel can point to which assists organizations like the VON to transfer their asset base, without getting into the description of what that is, to an MSA. Currently, I think the rules don't identify an MSA, but would an MSA qualify for the current generally accepted agreement between the federal and provincial governments as to what constitutes a legitimate transfer agency of those assets?

Ms Czukar: The legislation addresses this in that the MSA can be, and is expected to be, an independent non-profit corporation under the Corporations Act. The legislation doesn't address the issue of charitable status, which of course is a question of federal law under the Income Tax Act and being tax-exempt and so on. If an MSA does obtain charitable status, and it's anticipated that most would, then the rules governing the disposition of assets of both a non-profit and a charitable corporation would apply and they would have the usual reporting relationships and so on.

I don't think there's anything special that needs to be done about that. The general law would take care of the disposition of assets from one charitable organization to another. What the act says about that is just that if the bylaws of the existing organization don't have any provisions that specifically address disposition of assets on dissolution, then the general law would be that it's supposed to go to another non-profit charitable corporation that has similar objects, and the MSA would have similar objects.

Mr Jackson: It was on the point of—in two stages. Are MSAs going to be applying, which would be a provincial application, for a non-profit corporation? A charitable non-profit corporation is limited in the province of Ontario if applied to Ontario, but if its extended definition requires federal approval, are we expecting MSAs to do this in a haphazard manner, or will they be constructed legally to receive the transfer of these funds? Well, the transfer of funds: It's a transfer of funds and assets. You've got money in the bank and you're dissolving a VON and those funds have to be somewhere. Potentially, they could go to an MSA. That's the point I'm getting at.

I ran into this when I set up some food banks in Burlington, and we had a range of options of the charitable status and its implications. I just wonder if the legislation anticipates that and prescribes a receptive, legally binding host for those funds.

Ms Czukar: The legislation doesn't address the issue of charitable status. I'm not aware of particular problems that would be encountered by an organization that is charitable and wants to transfer to another charitable organization. If there are special problems that the legislation needs to deal with, I'd be happy to hear that, but we expect that MSAs would obtain charitable status. We haven't required them to. But I think the short

answer to your question is yes.

Mr Jackson: Finally, why I'm trying to bring this around is from the concerns of the deputants with the potential for their dissolution, but also the very cogent argument they make about the loss of volunteer base. Volunteers also contribute money, because they believe in the actual extended work they're doing. Therefore, depending on the status of the MSA, they might not even be able to provide volunteer cash donation to receive a full charitable tax receipt in the province of Ontario.

So not only are their fears legitimate, but you're constructing the MSA in such a way that you couldn't make a contribution to it. That's all my point is, and maybe you'd like to comment on this notion that the way this thing's configured—although you do cover it well in your brief.

Mrs Laudadio: The only comment I'd like to make is that administering the home care program, all our donations that come in come to the Victorian Order of Nurses.

Mrs Karen Haslam (Perth): I'd like to again thank you for coming. I'm going to take up a couple of points.

I agree with some of the comments around case managers, and I've heard this before when I was out on my own and visiting with nurses. I think they are saying, "We would like to be the case managers," and I know there are professional case managers and courses for professionals to do this kind of job, so I hear your concern around having someone in a professional mode to take care of that case management.

What I'd like to address, though, is to take a look at point 5 of your concerns, and that was loss of volunteers. I think we take a look at the patchwork of services out there and say that is a result because there were groups that saw gaps within the system and that's why we have the patchwork out there. So I see Bill 173 as setting the stage for local volunteer initiatives, but more along the planning of the health care that's necessary in a community rather than another volunteer board—not that they don't do good work, but that it's time we took a look at the overall picture and did a little more planning.

So when we talk about VON, and you're talking about loss of volunteers and how an MSA will affect that, I see VON as being a rather large organization, larger than a local MSA, and you have not had problems—at least you don't tell us you have problems—in keeping your volunteers when you are a rather large organization.

1420

In my community I see the volunteers who volunteer in many committees. I don't think I know one person in my community who volunteers only once or only in one of those agencies out there, and I see their commitment to their community as well as their commitment to perhaps one or two of the volunteer organizations they serve on. I see that they're serving on more than one board or they're serving on only one board as a display of their commitment to the community that they're in. So I question the loss of volunteers on two avenues, both of those avenues.

But you did raise some very interesting questions

about, do we know how much and are we aware of the number of donated hours? Yes, we are. I would draw your attention to the volunteer service awards and the stats that are kept within the ministries around the volunteer hours and around the benefits of having volunteers in all communities and around the accolades they receive, both from governments and communities.

So I think I can answer yes to some of your questions. Yes, we are quite aware of the number of hours that go into volunteerism, but I just question where you see your total loss of volunteers in a community, because I know those volunteers are there in hospitals, a larger entity than some MSAs will be; I see those volunteers in many areas in the community. I don't see them being lost.

Mrs Opie: I think one of the points we wanted to make here is, certainly we're concerned about VON volunteers, but we're also concerned about the volunteers as a whole in our community who provide a front-line service that's provided by volunteers; not the individual who sits on three different committees within the community, but the individual who believes in palliative care and so joins an organization whose only focus is palliative care and that's their main direction and that's where they're putting the time.

The friendly visitors, the people who transport clients: Those are people in the community who have great commitment, have great belief in whatever organization they're joining and the base of that organization and the purpose of that organization. There are a lot of free hours we don't pay for under the home care program. That's one of the things we access. In frugally looking at our system and how we could do it, that's one of the things. We try to refer people to organizations that will provide it free, and that's a fear that we have, that we will lose those organizations out there. Within the city of Thunder Bay, within the small community of Manitouwadge-Marathon, they each have their own little resource group that has its own particular focus, and those are the ones we're afraid of losing.

Mrs Haslam: Actually, those are the same ones I'm talking about. It's the gentleman who drives for friendly services or for neighbourly services in my community, and he also volunteers at the hospital for the hospital work in the canteen, or the lady who works as a volunteer for friendly services is also a volunteer for the Heart and Stroke Foundation. What I'm saying is, I know one lady in my community, when she ran for council, gave up 11 volunteer associations and work in the community. What I'm saying is, I can see that commitment still being there. I think Bill 173 is trying to say those traditions are important, and we do want to see them continue.

Mrs Sullivan: There are a number of reasons that volunteers volunteer, and some of those reasons may be that they have a specialized interest in a certain kind of service. They may have a special attachment that's mission-oriented, as we see particularly in the faith-based charitable organizations. They may have a personal attachment due to an experience in their family. There are many reasons that a person volunteers.

But one of the things that has to be very clear is that the work that volunteers do is associated with the actual

care of clients of agencies, but also it's fund-raising work, and 30%, on average, of the revenues of volunteer organizations comes from volunteer fund-raising, and we on this side just can't imagine people volunteering to raise funds for what will appear in the community to be a gigantic bureaucracy.

I want to know, as a follow-up to an earlier question, if it's the expectation of this government that the Victorian Order of Nurses, that the Red Cross, that organizations like St Joseph's Heritage and other agencies that are currently involved in the delivery of long-term care, will transfer their funds and their capital assets to an MSA and on what basis the government has that kind of an expectation.

Mr Wessinger: I'm going to refer this to Mr Quirt, because I think that with the planning process under way, each community may come up with different scenarios relating to organizational—

Mrs Sullivan: It has nothing to do with the communities. It has to do with the government's expectations regarding what are now self-governing bodies, independently incorporated bodies, and what will happen with their assets and their funds. Does the government anticipate and is the government planning that those assets and those funds will become part of the assets and funds of the MSA?

Frankly, I don't believe that St Joseph's, by example, or the VON are going to automatically turn over all of their assets. If they don't, then the MSA is left to purchase, to spend a whole bunch more dollars, on capital assets when in fact we should be spending money on care instead of on buying assets and on severing people who are doing a good job already.

Interruption.

The Chair: Order, please. If I might just remind everyone, this is a legislative committee and the rules we must follow are those as if we were in the Legislature. I appreciate people have feelings about these issues, but I would ask if you not react to the different comments that are made by way of applause or any other manner.

Mr Wessinger: Before referring the question, I think it should be clear that if, for instance, the local MSA was created by means of an amalgamation of existing agencies, legally all the assets would vest in the new agency. If there's another mechanism, then undoubtedly a different situation would occur and I'll ask Mr Quirt to refer to those situations.

Mr Quirt: There's nothing in the bill that would require the VON or any other organization, the Red Cross, a not-for-profit organization, to do anything that they didn't choose to do with their assets. So it's totally up to the board of directors of the VON or the board of directors of the Red Cross or whatever organization may be affected to decide what to do with their own assets.

As was pointed out earlier, there may be some constraints on them placed by their charitable status in terms of what they would wish to do with them, but there's nothing in the bill, nor is there any expectation on the government's part, that the assets would be expropriated or the assets would be transferred. It's a decision for

those boards to make.

Mr Jim Wilson: Just a point of clarification on that: What good are their assets if you're expropriating the service? I mean, you're gutting their services that they're currently delivering, and they're going to be left with assets and no services or funding to deliver. You may say there's no expropriation of property or direct assets, but you're expropriating the service, so you're pulling the rug right from underneath them.

Mrs Sullivan: That's right.

Mr Jackson: Can I just demonstrate? I'd just like to illustrate in one sentence the concern. You take the VON, and they drive cars.

Mr Wessenger: —opportunity.

Mr Jackson: No, but listen. I understand that.

The Chair: I'm sorry. We're very tight on time. Mr Quirt will respond and then we are going to have to move on.

Mr Quirt: With respect to expropriating their service, the intention in the creation of MSAs is to provide more service, not less, and it's to use the valuable workers and their expertise in the system now and to build on that and to have more direct service workers through a local planning process; if in fact the MSA is formed from a new organization, to plan the orderly transfer of valued employees from one organization to the MSA and to the greatest extent possible protect their benefits and rights in that process.

The Chair: Thank you. I'm sorry. As Chair, I'm under greater constraints this afternoon because we have to finish at 4 o'clock and we've had our half an hour, but I want to thank you both for coming before the committee and for making your submission.

1430

COMCARE (CANADA) LTD

The Chair: I call on Ms Helen Berry, manager of Comcare (Canada) Ltd. Welcome to the committee. We have a copy of your presentation. Please go ahead.

Ms Helen Berry: Thank you for giving me this time to make my presentation. I am Helen Berry, a registered nurse and manager of Comcare (Canada) Ltd, a nursing and home support provider agency that has been a member of Thunder Bay's health care network and corporate community for the last 12 years.

I would like to express my opinions and concerns regarding Bill 173, specifically section 13, which requires the MSA to limit its purchases of community support services from other service providers to no more than 20% of the amount budgeted for specific services, such as homemaking, personal support services and professional services.

In order for me to express my concerns and make my point, I need to turn back the clock 12 years and tell you about how Comcare has served and benefited this community. It is my hope that you will understand that it is important for the system to have a healthy component of competition which brings innovation, flexibility, cost control and consumer choice.

Twelve years ago, Comcare was welcomed as a

provider of homemaking services by the Thunder Bay Home Care program. At that time, and over the last 12 years, the Thunder Bay Home Care program was experiencing growth and the only not-for-profit homemaking provider was unable to accommodate the increased referrals. Comcare, with our training programs and commitment to becoming a partner within the health care community, began meeting the increased need.

Comcare brought in more evening, night and weekend coverage for Thunder Bay's frail elderly, disabled and ill clients. Comcare also introduced shorter shifts and, later, one-hour shifts at the request of the home care program. A client's 60 hours, allotted monthly, could then be better utilized. Even though shorter shifts are much more difficult to coordinate, one knows how much this service means to someone requiring daily care services.

Over the years, Comcare has also worked very hard to keep an available supply of trained home support workers on hand as they were required by the Thunder Bay Home Care program. Our home support workers and the clients they service have also greatly benefited from Comcare's special training programs on palliative care, Alzheimer disease and AIDS, and our investment in home support training through Confederation College.

Comcare also has had a very extensive field supervision program for our homemaking services. I cannot emphasize enough the importance field supervision plays in the provision of a quality home support service.

Our presence in Thunder Bay has resulted in increased provider capacity, flexibility, quality and a fresh responsiveness. Currently, Comcare employs over 105 community care staff and delivers over 100,000 hours of in-home care annually.

In April 1993 the government of Ontario announced the redirection of long-term care. As part of this redirection, the government announced and implemented a policy requiring home care programs to reduce the amount of service being provided by commercial firms to 10% of budget within a specific time. This decommercialization policy, in essence, required home care programs to formulate transition plans to achieve 10% limits.

The VON-run Thunder Bay Home Care program, like many home care programs, began implementing the not-for-profit preference decommercialization policy. All referrals to Comcare were stopped as of June 28, 1993. Even readmissions were directed to the Red Cross. A referral base that had taken Comcare 11 years to build up was just handed over to the local not-for-profit provider. Over the last 12 months, Comcare has had to lay off or cease employing over 55 community care workers. Very few of these employees ended up working for the Red Cross; actually, none that I am aware of. They left the community care field confused, angry and disillusioned.

The clients to whom we were entrusted to provide care also felt the impact of the decommercialization policy. These clients faced disruption, lost their care givers and complained openly. Some even stated that they would rather just pay privately rather than face the loss of a valued care giver or be forced to switch to a provider not of their choice. Unfortunately, the change in policy, to stop the decommercialization, came too late for many

clients and home support workers.

Meanwhile, a very rigid not-for-profit referral preference continues to be practised. As a result, we continue to downsize and lay off workers while trying to maintain our reputation for quality. Our company and, most importantly, our staff are getting squeezed out of the system, hardly fair treatment for front-line staff who have worked for years providing home support services for our community.

As mentioned previously, we have lost over 55 community service staff and Comcare's monthly volumes have decreased over 30% monthly in the last 12 months. I cannot begin to express to you how demoralizing and disruptive this downsizing has been. I have not seen, the clients have not seen and the community has not seen any benefit from the decommercialization efforts or from the not-for-profit preference policy.

To summarize, I sincerely feel that the difficult lessons the government has learned in 12 months of decommercialization can provide us a glimpse of how the system will respond to consumers' needs under an MSA model that does not have room for a balance of not-for-profit and commercial providers.

(1) Consumers will lose choice. Consumers are both the clients and the case managers who must select agencies according to their strengths and abilities.

(2) MSAs that are direct service providers will essentially be monopolies. Innovation, flexibility and cost control will be dampened.

(3) MSAs that are full-service providers will experience higher costs per unit of service delivered, regardless of the limited efficiencies to be gained by an agency amalgamation.

(4) The system will lose its flexibility to meet the diverse scheduling requirements of clients.

(5) The capital and investment brought to the community by the private sector will be lost.

(6) Lastly, non-unionized community care staff from both the not-for-profit and commercial sectors face tremendous disruption.

1440

In Thunder Bay, if the MSA is implemented in accordance with current Bill 173 provisions, Comcare will cease to exist. After 12 years of hard work and positive contribution, our employees will be gone, our commitment eliminated, our local investment lost and our proud presence forgotten. This is not necessary and I urge the panel to listen to my recommendations.

(1) The government should allow local communities to structure their MSA service delivery mechanisms in accordance with local needs and provider abilities and in ways that ensure the most effective use of financial resources.

(2) Section 13 and the requirement that MSAs be direct service providers must be changed to allow for continued contractual relationships without limits.

(3) Providers should be selected according to quality and standards criteria.

(4) The current not-for-profit preference should be

relaxed to allow programs to meet the needs of consumers.

(5) Comcare fully supports the concept of one-stop access. One-stop access can still be accomplished without dismantling an effective system of provider agencies, charities and volunteer groups.

(6) Lastly, provider agencies should be governed by province-wide standards and be held accountable to local boards and the consumers to whom they are entrusted to provide care.

Thank you for giving me this opportunity to speak.

Mr Dalton McGuinty (Ottawa South): Thank you very much for your presentation. I think the comparison you make between the government's decommercialization policy and the ultimate effect of Bill 173 is a good one. I think there's a lesson there for us to learn. I have never personally felt that people who earn a profit are somehow excluded from being able to deliver quality, compassionate care. I just fail to see that argument. I don't see any merit in it. I don't see how there's any reason why people who make money, who run a business, cannot deliver that kind of care.

You make reference to the fact that consumers will lose choice. I heartily agree. I think one of the important rights they're going to lose is the right to fire somebody who's not providing the kind of care they feel they're entitled to. The act, in kind of an effort—and I think there's some merit to it—talks about rights that are going to be given to clients through its bill of rights. It says, in particular—and I think I'm leading up to a question here to legal counsel—that there's going to be a contract, I guess a formal, legal contract, will be deemed to exist between a provider and a client.

I'm just wondering, and I'll direct this to legal counsel, if I'm 73 years of age and I feel that one of my rights has been breached, what remedy do I have? Whom am I suing and what am I suing for?

Ms Czukar: The provision in the bill which addresses the deemed contract says that the contract is between you, the consumer, and the service provider, so you would be suing the service provider and you would be suing them for the breach of contract. You would refer to the seven, I believe it is, points in the bill that describe what the terms of that contract are and you would have to establish that one of those rights had been breached.

Mr McGuinty: Am I suing, though, for—am I entitled to money?

Ms Czukar: You would attempt to translate that breach into money, yes. You would seek money damages. You might also seek some kind of specific performance, something that would say that if you felt you hadn't been treated with dignity and respect, or something like that, you would seek an order against the service provider that they do that.

Mr McGuinty: My reaction to that is that, if we use my example, if I'm 73 years of age, there's an excellent chance that I am not familiar with the legal system, I'm not familiar with our system of justice and it would be impractical for me probably to retain a lawyer, to wait the one year to two years it would take to resolve this

matter in court when at the present time, under the existing system, I have the right to fire somebody who's not looking after me properly. Yet, if my service is being provided by a multiservice agency, I have effectively no choice to go elsewhere.

Ms Berry: That's exactly it. Right now, under our present system in Thunder Bay, for instance, clients have a choice of four agencies that they can access for home-making services. That's the way it was. Right now, it's basically the not-for-profit that is being accessed for homemaking services.

Mr Jim Wilson: Thank you, Ms Berry, for a very excellent brief and in fact one of the first briefs to give us some numbers with respect to the effect to date of the government's preference for the not-for-profit sector and its 10% rule. As the Health critic for the Ontario PC Party, I just want to tell you that you can take it on my word, on behalf of our caucus, that, first of all, we will introduce an amendment to get rid of all reference to the 80-20 rule in this legislation.

Secondly, over the last 10 years, we've not in any way supported this social experiment of the other two parties to dictate market forces. We think the local community and the market, the consumers, should clearly have the choice and dictate to local service providers to whom and by whom services should be provided. That was the policy for many, many years and as a result we had a balance.

Ms Berry: It worked very well.

Mr Jim Wilson: It worked very well and service gaps were filled by private sector and the not-for-profit or more public sector. They got along very well and we had a balance. Government just has no business dictating market forces in this case.

Ms Berry: I'm happy to hear that.

Mr Jim Wilson: The second thing is, and I want to ask you on that line, at what point do you lose the critical mass in your business and eventually are forced out of business, and if this ridiculous policy continues, how much longer can you hang on?

Ms Berry: That's exactly the point. When there was a total loss of referrals to Comcare at the start of the not-for-profit preference policy directive, we felt we would be out of Thunder Bay within six months. At the rate we're going right now, it looks like we'll be down to zero in two years. We've lost one third of our volume so far.

Mr Jim Wilson: That's probably because we hear from a lot of commercial agencies that in fact in many areas of the province local managers of the Ministry of Health or Comsoc have actually not enforced the 10% rule because it would lead to too large of a service gap. Otherwise, many more employees from the commercial sector would be on the streets. Have they been very stringent on the 10% rule here or have they found that it's unworkable?

Ms Berry: I'm not quite sure just what you're—

Mr Jim Wilson: In some areas of the province, although the law right now is that you're to be limited to 10% of the market, if they did that, there certainly would

be a number of citizens out there with no service whatsoever. So they've been flexible on it.

Ms Berry: Right. Thunder Bay had a deadline of March 1995 to come down to 10%. The Thunder Bay Home Care program, I imagine, had felt they should be meeting that deadline, and so commercial agencies here were going down fast.

1450

Mr Jim Wilson: The other thing is, on page 3, point 3, it says, "MSAs that are full-service providers will experience higher costs per unit of service delivered, regardless of the limited efficiencies to be gained by agency amalgamation." I just want to tell you that, to date anyway, the government has not been able to provide any proof whatsoever that there will be any efficiencies at all as a result of amalgamating all of these agencies.

In fact, history—if we've learned anything in this province—is that bigger isn't better. Regional government has been more costly in this province. School boards, when we amalgamated those, have been more costly. Now this is sort of regional government in health care. I would even suggest that perhaps you were being kind in point 3 by saying that there might be some limited efficiencies by extrapolation here. In fact, the government in no way seems, in spite of all of our challenges, to come forward with any efficiencies at all.

Ms Berry: Our research has found also that in other places that have tried bureaucracies such as the MSA it just has not worked.

Mr O'Connor: I appreciate your presentation. I guess that's one thing that we have heard clearly, that the bureaucracies in other jurisdictions haven't worked. That's exactly why, for example, the limitations on the 20%. It's important that we work towards achieving that and that the planning take place, that the district health council subcommittee on long-term care actually does the planning that is necessary, so that we don't have a need to create bureaucracies or support the patchwork that is in place today.

My colleague suggested that it's ideological, the reason we want to move with a limit of 20%. The fact is, it's a very pragmatic move and it's one that is going to make sure that the planning that's needed takes place. Not every jurisdiction's had placement coordination in the past; a lot of them do now as a result of Bill 101. Quick response teams that are around the province now have come together because their communities have recognized a void and a lot of partnerships have taken place that didn't take place before. It wasn't there in the past.

So, for all the long-term care reform that my colleagues opposite have talked about for over a decade, there's finally a movement to see that take place, and the movement is necessary.

The dollar commitment by the government is important; \$850 million this fiscal year is going to be placed in long-term care on the community side. They may balk at that, but when we took power, the very first year, it was \$550 million; \$300 million more is going into it this year alone. There is a huge commitment to see that this takes

place.

There are 5,000 more jobs being provided in long-term care in the community now than there was then. There is a commitment. It's real, it's tangible and it's taking place. I think that one thing that your organization has done probably—and the Red Cross is up next—has been that by you being there and offering services it has probably made them a little bit more efficient in delivery, and they'll probably point that out to us when they make their presentation.

The fact is, there are a lot of pragmatic reasons for all that needs to be done in this legislation. Quite often, what we don't hear about are the consumers and the consumer involvement in establishing what can develop locally in their own communities and making sure that the services that they need, that are there today in a good many communities but not in every community—the patchwork that's there now can be eliminated by putting down something in enabling legislation.

Mr Jackson: Do you understand who you're talking to?

The Chair: Order.

Mr O'Connor: I appreciate you coming here and presenting your views and we've got quite a bit more—

Mr Jackson: You should apologize for taking her job away.

The Chair: Order.

Mr Jackson: Just apologize for taking her job away.

The Chair: Order.

Ms Berry: I'd just like to—

Interjection.

The Chair: Mr Jackson, order please. Mr O'Connor had the floor and now the witness will respond.

Ms Berry: I would just like to comment on the 10% that this government had in last year. It's now been changed to 20%. If last year 10% didn't make any real common sense, I don't really think that 20% will either. They should change it back to a mix of not-for-profit and commercial providers. There shouldn't be any not-for-profit directive preference policy.

Mr O'Connor: I appreciate hearing that. We've heard a lot of people in the past make a presentation saying they didn't want to go to the brokerage model as prescribed by previous governments. There's a mix. All this is going to be recorded and we'll take a look at that as we evaluate and get into clause-by-clause.

The Chair: Thank you very much. The parliamentary assistant just had a point of clarification he wished to make.

Mr Wessinger: Yes, I'd just like to make a point of clarification. I'd like to thank the deputant. I have some degree of concern about some of the points made. Because, as I understand, what happened when the legislation was introduced in May 1994 was that the commercial volume was frozen at May 1994 levels and that there'd been no reduction of levels of the commercial sector since that time. That's certainly the information we have, so there's a certain degree of concern about your comments about the number of layoffs and the volume

decrease.

Ms Berry: It's certainly been a concern of ours, losing this many trained homemakers.

Mrs Sullivan: Point of order, Mr Chairman: The minister announced a policy in 1993. Many, many home care agencies around this province began to implement that policy, which was supposed to be fully put into effect in 1995, in the early part of 1995. Thunder Bay clearly started to implement that policy soon after it was announced by the minister.

The Chair: Order.

Mrs Sullivan: For the ministry and the parliamentary assistant to suggest—

The Chair: Mrs Sullivan.

Mrs Sullivan: —that they don't know of anyplace where it happened—we've just had a full deputation—

The Chair: Order, please. The parliamentary assistant asked to make a few comments about the presentation. I'm going to allow the deputant to respond to that, but then we must move on.

Mr Wessinger: Just to reiterate, it was clear the point was made that volumes were frozen at May 1994 levels. Has there, in your opinion, been any reduction in volume overall since May?

Ms Berry: A 30% reduction in volume to our agency since May 1993.

Mr Wessinger: Oh, May 1993.

Ms Berry: Yes.

Mr Wessinger: So most of the reduction would have occurred in the period prior to 1994 then?

Ms Berry: Yes.

The Chair: Thank you very much for coming before the committee this afternoon.

The Chair: If I could then call on the representatives from the Canadian Red Cross Society, Thunder Bay and Northwestern branches.

Mr Jim Wilson: Mr Chairman, while the deputants are coming forward, could I just ask for a clarification from the parliamentary assistant on the \$850 million? Is that—

Mr O'Connor: A 54% increase.

Mr Jim Wilson: How much of that, though, is made up of consumer user fees? I only ask that because when you announced \$650 million at one time a couple of years ago for the long-term care institutional side, facilities, \$150 million of that turned out to come out of the pockets of residents of those facilities in the form of user fees. What's the breakdown of the \$850 million?

Mr Jackson: Tommy Douglas would be real proud of you guys.

Mr Wessinger: I don't know whether Mr Quirt can reply to that now or whether it's something we will provide you with.

The Chair: Can we get that information just so we can—I'm just concerned about our time. We have a real time problem.

Mr Jackson: Point of order, Mr Chairman: This com-

mittee has still a standing request for a detailed explanation of the economic breakdown. In the briefing that occurred the other day, it was not included. There are holes to be plugged in these figures that are floating around and they're being misrepresented, and to delay the full briefing of the financing is a dishonest approach on the part of the government, which has these facts. I think it's the responsibility of the Chair to get them forward for us so that we don't engage in this nonsense.

The Chair: I will take it as Chair of the committee to work out with the parliamentary assistant—

Mr Jim Wilson: You say it's a 54% increase, but the last time you did this you had seniors with a 47% increase in user fees.

The Chair: Order, please. We need to move on and we have this discussion at another time, because I know we have limited time.

1500

CANADIAN RED CROSS SOCIETY,
ONTARIO DIVISION,

THUNDER BAY AND NORTHWESTERN BRANCHES

The Chair: We want to make sure to provide you with all of your time. Welcome to the committee. If you'd be good enough to introduce yourselves, then please go ahead with your submission.

Ms Sonia Prodanyk: Good afternoon, Mr Chairman and committee members. My name is Sonia Prodanyk and accompanying me this afternoon are Prue Morton from Thunder Bay and Fran Ormiston from Kenora. Prue and Fran will provide a few words of introduction prior to their presentation.

My name is Sonia Prodanyk. I have been a Red Cross volunteer for the past five years. I serve as the northwestern region homemaker representative on the Provincial Homemaker Services Committee. My duty is to bring the northwestern perspective to Ontario division. I also sit as a member on the local Thunder Bay Red Cross homemaker committee and on branch council. I am the program coordinator and instructor of home support levels 2 and 3 delivered by Confederation College.

My father was a recipient of homemaker services and I am a very strong supporter of the services provided by homemakers enabling clients to remain in their homes rather than being institutionalized. I would like to take this opportunity to share with you what Red Cross means to the people of northwestern Ontario.

Northwestern Ontario has a large number of remote and sparsely populated communities. Geography, road, and weather conditions are an ongoing challenge to service delivery in this area. Red Cross has a long tradition in providing service to this vast geographical area. Homemaker services are provided by two main branches, one located in Thunder Bay and one in Kenora.

From our Thunder Bay and Kenora offices, we provide services to Nipigon, Red Rock, Terrace Bay, Schreiber, Marathon, Manitouwadge, Geraldton, Longlac, Fort Frances, Rainy River, Emo, Dryden, Ignace, Red Lake, Ear Falls and their surrounding areas. In all of these communities except Thunder Bay, Red Cross is the only provider of homemaker services. Thunder Bay has pro-

vided services for 46 years, and in its district area for eight years. Kenora has provided services for 25 years, and in Dryden and Fort Frances for well over 10 years. As community needs have been identified, Red Cross has readily expanded its services to these remote communities.

The development of suboffices has enabled Red Cross to provide a cost-effective and efficient way of delivering homemaker services in this area while maintaining provincial standards. Administrative functions are supported from the main branch office, while service delivery and supervisory functions are delivered in the suboffices. Across the province, the Red Cross operates 78 local branches that provide more than five million hours of service annually. Red Cross is unique in the manner in which we deliver and support our services.

At the provincial level, we pool the resources and experiences available to us from our local branches to create comprehensive provincial standards and tools: for example, quality management and risk prevention, proactive occupational health and safety programs, and relevant and timely training. This ensures that our clients receive the same standard of service in the north as they would from any other Red Cross homemaker program in Ontario.

In some areas in the north, the cost to deliver service exceeds the fee we receive. It is very expensive to provide services to very remote and sparsely populated communities. Red Cross has demonstrated its commitment to provide services to these areas.

More than 5,000 people in northwestern Ontario—the elderly, the frail, and the vulnerable—depend on the society, our volunteers and staff. Each month in northwestern Ontario, Red Cross provides 22,000 hours of homemaker service to over 1,400 clients by 335 homemakers in more than 17 communities. Let me take a moment to describe some of our client needs.

Example 1: a male client, 93 years old, blind from a stroke, with no bladder control. He has been a Red Cross client for 15 years. He lives alone and he is determined to remain in his own home. He receives seven-day-a-week service, 8 to 9 in the morning, 12 to 3 in the afternoon, and 8 to 9 at night. He requires assistance with activities of daily living such as bathing, changing Attends, meal preparation, guidance when walking—he utilizes a cane—housekeeping and laundry. This client would have been hospitalized years ago without homemaker service.

Example 2: a female client, 43 years old. She had a radical mastectomy and chemotherapy for breast cancer. She has five children under the age of 12. We provided service five days a week, nine hours per day, for over two years. Our services included child care and home maintenance. The father had to work to support the family. Red Cross assisted in keeping this family unit going until she regained her health.

Example 3: a female client, a 79-year-old widow who lives alone in a rural area. Legally blind, hard of hearing, she came on the program with a fractured ankle a year ago. She uses a cane now. She requires a homemaker for personal care, housekeeping, laundry and meals. Her

family is supportive and provides evening and weekend care but cannot do more. We have prevented institutionalization and care giver burnout.

Example 4: Homemakers have assisted in caring for quadruplets for a period of six months, spending six hours per day, seven days a week, to support this family.

The goal of the Red Cross homemaker service is to assist individuals and families to attain or regain their independence, to maintain themselves whenever possible in their own homes, and to enhance the quality of their lives.

You will also note that our services are provided not only during the day, but in the evenings, during the night and on weekends. When homemakers are in the field working, they must have access to a supervisor should they require assistance. Therefore, we have supervisors on call in the non-traditional hours. Through technology, we have linked branches and suboffices, allowing us to develop a regional on-call program. This enables one supervisor to be on call for the entire northwestern region. This has dramatically reduced our on-call costs while maintaining our quality management for our clients and homemakers. We have had to be particularly innovative in our approach to service delivery in northwestern Ontario in order to meet our standards cost-effectively.

While strongly supporting the principles of long-term care reform, we have grave concerns about the current draft of Bill 173, An Act respecting Long-Term Care. Prue Morton will summarize the position taken by the Red Cross on the creation of MSAs.

Ms Prue Morton: My name is Prue Morton. I've been a Red Cross volunteer for many years, first as the regional representative for northwestern Ontario homemakers and now as chair of the Thunder Bay Red Cross homemaker committee. As a former registered nurse and a secretary of the Thunder Bay chapter of the Patients' Rights Association, I am well aware of the important role that Red Cross homemakers play in this community.

I'd like to present the Red Cross position on MSAs.

Although we support the principles underlying the reform and the purposes as outlined in Bill 173, we're not able to support the creation of MSAs as described in the act. We're concerned the proposed system will not improve the delivery of services to consumers. We're also concerned that the legislation is trying to fix problems with the service delivery system through the creation of complex and highly bureaucratic organizational structures.

The existing system has many strengths. We are concerned that with the creation of MSAs as described in the act, these will be lost. The province-wide mandate of the Red Cross has enabled us to identify a number of opportunities to initiate systemic changes that would build on the system's existing strengths, increasing efficiency and improving quality.

The legislation, as it is currently drafted, precludes the Red Cross, its regions, branches or programs from becoming an MSA or providing services as part of an MSA. The Red Cross is committed to meeting the needs of the vulnerable members of our communities, building

on the range of services that we have developed over the last 75 years.

The Ontario division of the Canadian Red Cross Society is not a distinct organization but is part of a nationally incorporated entity, the Canadian Red Cross Society, which in turn is part of the International Red Cross and Red Crescent Movement. It has a long history of effective and efficient service throughout the world.

There cannot be more than one Red Cross in any one country. We operate under the bylaws established by the society. These describe the authority and organizational structures and set parameters for our operation. The society has only one board of governors, and this board is ultimately responsible for the overall direction and operation of all aspects of the society. No agreement or arrangement may be entered into that would in any way diminish the authority of the society's board or impinge on the society's fundamental principles, particularly:

—Independence, which states that each national Red Cross society must retain its autonomy.

—Unity, which states there can only be one Red Cross in each country.

The legislation requires that each MSA must be incorporated under the Corporations Act, Ontario, or the Co-operative Corporations Act, Ontario. Each MSA must have its own board of governors selected in accordance with the act. These requirements are incompatible with the fundamental principles and corporate structure of the Canadian Red Cross Society.

In summary, Bill 173 specifically excludes the largest provider of homemaker services in northwestern Ontario, the Red Cross. We have provided homemaker services, a cornerstone of long-term care, in an efficient and economical manner for decades. To specifically exclude the Red Cross from participating in long-term care may be a regrettable decision and causes me great concern. Don't throw the baby out with the bathwater.

Now Fran Ormiston will comment on specific aspects of Bill 173.

1510

Ms Fran Ormiston: Good afternoon. I'm Fran Ormiston. I'm a physiotherapist and I've been involved with health care for the past 25 years. Presently, I work in an acute care hospital in Kenora. I am well aware of patients being discharged early from hospital and the need to have support in the home.

My involvement with the Red Cross homemakers includes being a volunteer member of the Kenora-Kewatin Red Cross branch, teaching the home support level 2 program, providing in-service to homemakers, and serving as the chairperson of the Red Cross homemaker committee in Kenora. I believe homemakers have a vital role in long-term care. I see Red Cross as one of the essential providers allowing patients to be discharged successfully back to their homes. As we discharge people from the hospital, we must invest in the community to support not only the individuals, but also their families who must cope with their return.

We welcome the opportunity to comment on Bill 173.

The Red Cross recommends that three sections of the

legislation be amended. We believe these amendments would in no way adversely affect the purposes of the act; rather, they would enhance flexibility and allow the existing strengths of the system to be augmented.

I would like to comment on three sections of this legislation. The submission prepared by the Ontario division of the Red Cross contains three specific recommendations for amendments to this legislation. A copy of this submission has been distributed to you.

Looking at part II, subsections 2(3) to (7), inclusive, this section designates the community services which are to be provided by the MSAs. The bill describes four categories for these services and specifically delineates the services that fall under each category. The bill describes community support services, homemaking services, personal support services, and professional services. The basic premise underlying the breakdown appears to be to separate personal care, or hands-on care, of the person versus the non-personal care and services. We have two concerns with this aspect of the legislation.

The division between homemaking and personal support services is inconsistent with current practice and emerging future trends. It has taken concentrated effort over the past few years to erase the apprehension that homemakers are nothing but cleaning ladies, subservient to the other members of the health care team. The wording of the legislation significantly devalues the role of the homemaker and may lead to a reversal of the growing appreciation of the homemaker as an integral member of the health care team.

The separation of personal care versus non-personal care and services appears to be impractical and may create serious difficulties for the management of service delivery. The delineation of services between two categories is inconsistent with the way services are usually delivered in the client's home. Many functions routinely provided by the homemakers cross the boundaries between what the legislation classifies as "homemaker" and that called "personal support."

We are also very concerned that the uncertainty arising from the reform has created significant anxiety for our staff. We must protect the interests of the almost 400 staff, mostly women, we employ in northwestern Ontario.

Part VI, section 13: This section stipulates that an MSA may not spend more than 20% of its budget to purchase community services. The government appears committed to moving away from the brokerage system. In our opinion, the problem with the current delivery system is not brokerage, but lack of coordination and poor access. We feel that in many situations brokerage can be an efficient and effective system for delivery of service.

Presently, many services are provided efficiently and effectively by a number of established agencies such as the VON, St Joseph's Heritage, and of course the Red Cross. These agencies have long histories of service to their communities. They are often supported and governed by volunteers who are part of the community. Stable relationships have been developed between provider agencies, care givers and the individuals they serve. Rather than replacing the existing system, effort

should be made to improve coordination and enhance efficiencies. One example would be to contract with a provider agency for blocks of service rather than the less efficient client-by-client contracting that now occurs.

Where MSAs are declared, and as they move towards assuming 80% of a given service, the critical volume necessary for the alternative provider to exist will be lost. The MSA will then be forced to assume responsibility for providing service before it is ready or, alternatively, clients will have to wait for service. The Red Cross is very concerned that clients may face waiting lists, a decline in quality of service, or limited—maybe even no—choice. Those who wish to purchase services outside of the MSA system will be unable to do so if there are no alternate providers in the community.

In many remote and sparsely populated areas like northwestern Ontario, the Red Cross is the sole agency providing this service. Our corporate structure and fundamental principles preclude us from providing services within the proposed MSA structure. We are concerned that if MSAs are imposed in these areas, the declining volume of service allocated to us, in combination with increasing deficits due to the high costs associated with travel, will ultimately force us out of business. This will leave many clients without service. Where the local MSA plans to assume responsibility for directly providing the necessary services to these clients, accommodation will have to be made to offset the deficit inherent in servicing these areas of the province.

Looking at part VI, section 15, this section says that MSAs have just four years to comply with all the provisions of the legislation. Under the tight strictures of this draft legislation, communities will not have the flexibility to identify and implement the models of service delivery that best suit their needs. The government has repeatedly stated that this is not to be a cookie-cutter approach. This provision appears to be contrary to that statement.

As the government reforms long-term care, it must look at building on existing successful programs such as the Red Cross homemaker program. The provision of high-quality service requires more than a set of manuals and the requisite number of staff. The Red Cross service is greater than the sum of our parts. Our strength lies in our ability to utilize our collective resources and expertise. The legislation must permit agencies such as the Red Cross to continue to provide excellent and necessary services to the residents of the province.

The Chair: Thank you very much. I'd just note for the record as well the attachment that you have given us with your brief. We have a number of questioners. I could just remind members of the committee that if we could direct the questions at the witnesses and keep our conversation moving that way, it would allow us to get in more questions, I think, to expedite our hearings this afternoon. We'll begin with Mr Malkowski.

1520

Mr Gary Malkowski (York East): Your presentation was very pointed, and we're very happy that you've come forward to list your concerns with us. We listened very carefully. Your feedback to us is important.

I've also been hearing feedback from some of the non-profit organizations. They talk about concerns of issues being that of volunteers and preserving the tradition of that volunteerism. So that has been identified.

You've mentioned that resources are scarce in the north, and it may be hard to secure some of these services. You're fearing of that since you in many ways are the only organization in some of these areas providing services to people. Well, we also value that.

I'd like to know a little bit, in this part of the section where it talks about the coordination of volunteers: If we were to strengthen that in terms of service delivery and service provision, have some kind of built-in mechanism within the legislation that would preserve and expand upon that whole role of volunteerism, is that something you'd like to see within the legislation? I'd like your comments on that.

Ms Ormiston: Volunteerism obviously is incredibly important, but so is professionalism, and the Red Cross has a unique balance of professionalism and volunteerism. You have to be careful that you don't have a volunteer going in to do brain surgery. As a result, this balance, and the balance in the north—again, as I said, the Red Cross homemakers often travel quite a ways. From Kenora, they may travel an hour into the Sault Narrows area. You can't always expect volunteers to do that form of travelling.

The volunteers certainly have a wide range of scope of helping the board and helping the homemakers in a variety of ways, but as I said, you have to be able to dissociate between volunteerism and professionalism, and I think the Red Cross does do this well.

Mrs O'Neill: Thank you very much for coming. As you likely know, the organization has presented in Toronto as well from their perspective.

I'm so impressed with your first page and the number of communities you serve. I wonder if you could just give us an idea of how many volunteers would be involved in that and how many clients in all those communities you mentioned. If you haven't got that, you can send it later.

Ms Ormiston: We'll send you that number, yes.

Mrs O'Neill: What I really want to know is, do these people, the people you serve and the people helping the professionals do their job, realize what's going to happen with Bill 173? Do they really realize the Red Cross is out of business, even though it won't be out of business a few miles down the road in Manitoba?

Ms Ormiston: I honestly do not believe the clients realize the impact of this bill.

Mrs O'Neill: I think we've got to get that message out. As I say, I think you're being very gentle today in your presentation.

Mr Chairman, I'd like to have the staff provide, maybe not now but in writing, the implementation that is expected from the announcement that was made in 1993 in the Legislature by the Minister of Health. There seem to be conflicting interpretations about that. I think it's important to groups like the Red Cross, and I think this committee has to know what's going on out there. Is it

universal across the province? Is each community making its own decision about how it's picking up this directive? What are the time lines, and the specific time lines? I think we have to have that as soon as possible.

The Chair: I'll take that as notice and we'll work out through the parliamentary assistant the response to that question.

Mrs O'Neill: Thank you.

Mr Jackson: Thank you for an excellent brief. Could you tell me, has your service been expanded in the last year or two years? How much has it expanded by in the last year?

Ms Morton: I can't hear the questions. Sorry.

Ms Prodanyk: He was just wondering if our service has expanded in the last couple of years.

Ms Morton: I don't think it has, not in our—has it in your area?

Ms Ormiston: Our population doesn't grow incredibly, you know; the numbers don't come up a lot. But we are certainly meeting very crucial needs.

Mr Jackson: Well, let me ask the question a little differently. We've just heard from Comcare and they've laid off 55 employees. In theory, one would suspect that there is work for 55 other people in that field if they've lost market share. If not, have we just seen that much reduction of access to this service in this part of northern Ontario as a result of—I mean, we listen to the government. They said they've been pouring all sorts of money into home care in this region so there would be an expansion of employment; in other words, expansion of service. Did you not expand your service to meet—so you didn't have occasion to hire any people, because you weren't hiring?

Ms Prodanyk: In the Kenora area they now are receiving services from the integrated homemaker program, and with that particular program being implemented in the northwest, the extreme northwest, yes, services have increased up there. In Thunder Bay we have received, again, more services because of the decline to the for-profit agencies.

Mr Jackson: So did you hire additional people as a result, or were the VON and St Joseph's the beneficiaries of the expansion? Or did you just remain the same? I'm trying to establish: There were four agencies and one's in radical decline. That leaves three that have the potential for the uptake of workers. I want to know if you hired additional workers in the last year.

Ms Prodanyk: Okay. I cannot give you specific numbers on the number of employees we did hire, but there were some employees who were hired and we certainly can provide you with that information from the staff.

Mr Jackson: I just wanted to establish, because the point was made that they were not hired by your agency and I'd neglected to ask the other agencies if a similar—

Ms Prodanyk: Okay, if it was the Thunder Bay area, or if it's in northwestern Ontario?

Mr Jackson: No, it was a Thunder Bay question, and the reason I wanted to raise it is that you make reference

in your presentation to "many services are provided," but then you listed only those three. I just wondered if it is in any way prejudicial to the private sector, because once you get past who owns the service, these are still women who need to work to put food on their tables. Many of them are single women trying to raise families. I would hope there's no discrimination occurring in terms of hiring these women simply because they took jobs they had to have.

I certainly would hope that's not the position of the Red Cross, although I've seen it occurring in other parts of the province. That's why I was pursuing that line of questioning, because I just really don't think it is fair to someone who's lost their job because the government made a decision and then when they go with those skills to get hired, they are discriminated against in terms of hiring.

Ms Prodanyk: Exactly. We can certainly provide the committee with the information from the staff.

Mr Jackson: Thank you.

The Chair: The additional information has been requested, if that can be conveyed to the clerk of the committee, and we'll distribute that.

Ms Prodanyk: Certainly.

1530

The Chair: Last, the parliamentary assistant had a point of clarification. Last comment, please.

Mr Wessenger: I'd just like to clarify that with respect to the functions between homemaking and personal services, there's no intention to divide the functions between different individuals. It's understood that those functions will be delivered, in many cases, by the same individual.

I just have one little question. The Red Cross, as you've indicated, has what might be called a very rigid, centralized governance model. I was wondering how successful you are with that type of legal model in providing for community governance at the local level through your branch system.

Ms Ormiston: If the community can become involved in a volunteer basis they can come to—we have an annual meeting every spring and any members of the community are certainly welcome to participate in that annual meeting, in any of the branch activities or in any way they wish to come forward. The Red Cross doors are always open to the community to come in and to participate in whichever way they feel meaningful to themselves.

Mr Wessenger: I suppose, to be more specific, what I'm referring to is the question of governance; for instance, decisions pertaining to who is employed as executive director, directions of policy—is that done by the local branch?

Ms Ormiston: We have input to that.

Mr Wessenger: Input to it but not final decision-making?

Ms Ormiston: A vote.

Ms Prodanyk: That is also handled by—we have a regional policy council and there is also Ontario division.

So they are all involved in that; it is not just a local decision.

The Chair: Thank you all very much for coming before the committee and for your submission and attendant documents.

ONTARIO COMMUNITY SUPPORT ASSOCIATION,
AREAS 13 AND 14

The Chair: I then call on our last presenter for this afternoon, Ms Karen Bergman, from the Ontario Community Support Association.

While Ms Bergman is coming forward, just to remind committee members that I will have to play Scrooge at 4 o'clock and end the proceedings; otherwise, we won't get to Sault Ste Marie and as much as I know we'd like to stay, we have to get to Sault Ste Marie.

Welcome to the committee, Ms Bergman. We've received a copy of your notes. Please go ahead.

Ms Karen Bergman: It's nice to be here this afternoon and to have the opportunity to present on behalf of the Ontario Community Support Association. My name is Karen Bergman, as you know. I am a director on the board of OCSA for area 13—actually a very recent board electee, as of June. As well, I am manager of the Red Cross homemaker service for Thunder Bay and district.

My work with OCSA is as a volunteer. I am a volunteer; I am also a care giver in our community and a lifelong resident.

I am presenting on behalf of area 14 as well, Kenora and Rainy River area. However, that includes Dryden, Fort Frances, Emo and all the surrounding community. Area 13, Thunder Bay and district, includes Marathon, Manitouwadge, Schreiber, Terrace Bay, Nipigon, Red Rock, Longlac and Geraldton.

Our presentation will begin with a brief overview of who we are and then we will give you the areas that we support and then our areas of concern.

The committee has already received a detailed written submission from OCSA at the recent hearing in Toronto, so in honour of our northwestern trees I did not reproduce it again because you have that in your possession. I do have a couple of extra copies should anyone wish them.

OCSA is an organization of direct providers of community-based services. Our primary purpose is to support, promote and represent the interests of community-based, not-for-profit health and social service agencies across Ontario.

OCSA was created on April 1, 1992, by amalgamating three provincial organizations. We hope that with the combined skills, knowledge and experience we would better serve seniors and persons with disability in Ontario. The associations that amalgamated are Meals on Wheels of Ontario, the Ontario Association of Visiting Homemaker Services and the Ontario Home Support Association. All of us have recognized a common interest in supporting community services and we have a long tradition of service in the community. In fact, 1993 was a special year for two of us; it marked the 25th anniversary of Meals on Wheels in Thunder Bay and also the

45th one for Red Cross homemaker service. These are well-respected and established services whose dismantling would be a tragedy.

OCSA is governed by a board of directors consisting of 25 community leaders from the province including representatives from the francophone and native communities. All are volunteers. Their combined experience of service provision at a grass-roots level guides the direction of OCSA.

We have 300 member agencies across the province. We have 10,000 dedicated staff, an army of 45,000 active, hands-on volunteers working diligently to provide a wide range of service. Many of our volunteers are seniors themselves. In 1993 these volunteers donated over 1.2 million hours of service. In northwestern Ontario our community support services include Meals on Wheels, homemaking, home maintenance, friendly visiting, telephone reassurance, home help, care giver relief, emergency response and transportation.

Each year over 600,000 Ontario residents receive help from community support programs. We do work with governments, related associations, the general public and the private sector to develop innovative and responsive strategies to expand community support services, and support the efforts of seniors and others with special needs to remain independent in their homes.

OCSA is subdivided into 15 areas which form the foundation of the association. Through this, members have an equal voice in the association, while each area has some flexibility to respond to needs identified by its own membership. Areas 13 and 14 encompass community agencies providing service in an immense geographical area, west to the Manitoba border and east to Manitowadge. One of the challenges facing our member agencies is the isolation and sparse population of many of our communities, and the travel required. Often innovative approaches are used: In Manitowadge the Meals on Wheels service has elected to try to deliver library books at the same time as meals and pick them up after. These are things we must do in the north.

One of the great strengths of a provincial organization like the Ontario Community Support Association is the direct, concerted voice provided. We work on behalf of seniors, disabled adults, member agencies and volunteers to ensure the issues which affect community service and seniors are heard and addressed by government policy-makers. We have been an active participant in the redirection of long-term care and support services in Ontario, so we appreciate the opportunity to share our perspective on this legislation. We do endorse several areas.

The association endorses the principles and values enunciated in Bill 173. We support not-for-profit service delivery where the principles of community-based planning, equity of access and equality of services prevail. We are committed to the development and implementation of standards of care and the continuing improvement in the level of service quality. We do agree with the purposes of the act, because the act does set out consistent criteria and accountability provisions governing service delivery designed to ensure accountability to the

consumer, to the government on behalf of consumers, and to the general public.

As to the bill of rights, yes, we are committed to a service delivery mechanism that is driven by individual consumer needs, which responds to the requirements of natural communities and their cultural diversity and that will support the development of equity of services across the province. OCSA supports alternative MSA models which endorse the principles outlined in the purpose of the act and which are a result of the community planning process.

Linkages with other social services and health providers is essential. Mutual respect among key stakeholders in the long-term care service delivery system will facilitate and encourage linkages among community service agencies with physicians, pharmacists, other health and social service professionals and community organizations. The act must ensure that services are planned, delivered and evaluated from an integrated health and social service perspective. OCSA also supports the changes to the public vehicles act which will allow a service provider to operate for the purposes of transporting persons determined eligible by an approved agency.

1540

However, we do have areas of concern. I will be presenting the six key areas. First of all, areas not covered in the legislation: There is perceived preferential treatment of unionized employees in the new MSA. Subsequently, in Bill 173 there are no references regarding the protection of not-for-profit, community-based employees as a result of implementation of long-term care reform.

Long-term care reform acknowledges the need for experienced, trained staff for the provision of service, yet the proposed process for development of multiservice agencies along with social contract reductions and constrained finances all currently have, or will potentially have, a negative impact on employment in the broader socio-healthcare sector.

Although there are similarities between clients in institutional settings and those in the community, the environments are quite different. Therefore, special consideration is required when hiring staff from facilities for community-based agencies. Training resources are required.

The community support sector consists of over 10,000 employees who are experienced and trained in the care and delivery of services. These staff have worked for years at low wages and minimal benefits with a strong commitment and loyalty to providing quality services. Unionized employees in the broader socio-healthcare sector are demanding priority employment in the community sector. Our sector is predominantly non-unionized and thus less able to voice concerns than organized labour bodies.

OCSA strongly believes there needs to be a commitment to fair wages and benefits for employees and there is also a need to ensure maximum expenditure on direct care service.

There will be significant human resource issues which

will require expertise, time and financial resources in order to be addressed successfully.

OCSA recommends that client continuity and respect for the relationships between existing employees and consumers of service should be paramount. Consequently, employee transfers to new agencies should be seamless, with no break in employment or client service.

All employees of not-for-profit community support service agencies should be guaranteed comparable positions in the new service delivery structures without loss of seniority. Otherwise, in all community support sector hiring, displaced employees from not-for-profit community support agencies should be given priority over other socio-health sector employees.

The second concern is under the general regulations. Bill 173 has taken an overly prescriptive approach to the provision of community-based services: 42 regulations have yet to be produced. Much is unknown. It's very difficult to respond when you don't have the detailed information.

The province is moving quickly to put MSAs into practice, yet major components need to be in place first. Where are the eligibility criteria? Where are the program standards? Where are the guidelines? Where are the regulations?

OCSA must be actively involved in producing and approving the regulations for 173. Furthermore, OCSA recommends that extreme caution needs to be applied in setting retroactive dates of application.

Our third area of concern, which has come up this afternoon, I note, is volunteerism in the reformed long-term care system. Volunteerism is an essential component in the delivery of community-based services. The volunteer base must be recognized as being deeply rooted in the community and potentially fragile. Some of our agencies in northwestern Ontario are totally volunteer driven and they have no paid staff whatsoever. Meals on Wheels services in Marathon and Manitowadge are totally volunteer. This needs to be recognized.

If they are not properly maintained, costs will skyrocket. This is essential service. Someone has to provide it and therefore multiservice agencies will not be cost-efficient and the ability to meet existing consumer needs will be jeopardized.

There is a lack of detailed planning regarding volunteers and long-term care, and there's also a concern about an inadequate number of volunteers currently in our area.

Our response from OCSA is to let you know that volunteers have been the backbone of community support services and they must be recognized and the issue addressed. The relationships presently existing between service agencies and their volunteers must be fostered and nurtured.

Volunteers must be kept well informed and actively participate. We need sufficient resources to support a volunteer management structure at each community level and on an ongoing basis.

Therefore, in the legislation we recommend that there be recognition of the role of volunteers. We recommend that volunteer management in regulation 11 be expanded

to require MSAs to develop and implement a plan for the recruitment, training, scheduling, supervision, retention, recognition and expense reimbursement of volunteers.

It is essential to maintain the linkages. Volunteers are motivated by an array of factors and cannot be shifted organizationally away from their work without risk of loss.

Fourth, multiservice agencies are a concern. It is essential that there be sufficient flexibility—and that is the key word—to allow communities to develop an MSA system to meet local needs. It is unclear what this final model will look like in each community until the community planning process is over. It is premature to assume that the same model will meet the needs of all residents in Ontario.

One-stop or single access does not necessarily mean that all services and care providers have to be assembled under one roof and that consumers have only one point of contact in the community. OCSA supports different models for MSAs which endorse the principles outlined in the act and which are a result of the community planning process. OCSA believes that MSAs must not be allowed to develop into large bureaucratic organizations; they must be small enough to be able to be responsive to local community needs. OCSA believes there must be consistent standards developed.

Improved coordination and access to available services are highly desirable. Communication among providers is key. We in the northwest have been very proud of our ability to work together. There is very little duplication of service in our smaller communities. There is one Meals on Wheels; there is one homemaker service; there is one home support program.

OCSA recommends that if functional integration is pursued, top priority must be given to ensuring that there is an effective computerized information network in place. This must include a financial commitment to design, hardware, software, training and support.

Our fifth point is the separation between community support services, homemaking, personal support services and professional services. This reinforces a hierarchy of services ultimately geared to medical needs rather than fostering a continuum of care. It reinforces a split between health and social services and moves away from wellness, health maintenance and prevention. This is inconsistent with the purposes of the act.

The distinction between personal support services and homemaking services is contrary. The province is pushing a generic worker which would combine health care aides, homemakers, home support workers, home helpers and attendant care workers. In most agencies, personal support services and homemaking are given by the same person. These services are provided concurrently.

There are concerns about how these two services will be operationalized. This separation will be an administrative nightmare for the service provider. If you're bathing a client, and that's personal care, can you wash the tub out after? Can you clean the sink? How do you split those two services? How can you go in to someone who is so frail that they need help with the bath? They must

need help to vacuum, to dust, to get their groceries. How can those be split? I can't understand it.

1550

New terminology is being used as well and this may lead to some confusion. Personal support services were previously known as homemaking, and homemaking is now being used to describe what's now home help. It is very confusing.

We question the use of the four categories. We recommend that the artificial distinction between homemaking and personal support services be ended by combining them. OCSA would like to be involved in that development. We also recommend that community support services, homemaking, personal support services and professional services be combined into one category.

Our sixth area of concern is the definitions. For example, definitions are not provided for services such as respite care, social or recreational services, security checks and reassurance services, friendly visiting, home maintenance and repair.

There is extensive detail provided for homemaking and personal support services, yet professional services are listed and not defined.

Also under the definition, this draft of the legislation refers only to incorporation under the Corporations Act, Ontario, and the Co-operative Corporations Act. However, there are nationally incorporated bodies where special consideration needs to be given. For example, since the Canadian Red Cross Society, whose Ontario branches are members of OCSA, is nationally incorporated and governed, it does not comply with the conditions for an MSA, as outlined in the legislation. OCSA recommends that incorporation under the federal corporations act be added. That recommendation will be found in your detailed submission on page 6.

We believe OCSA must be involved in the development of definitions of services to be provided.

In conclusion, OCSA applauds the leadership demonstrated by the provincial government through the development of Bill 173, which establishes a key building block in the foundation of the new long-term care system. We appreciate the commitment to building partnerships within the community to effectively plan and implement meaningful change. We do look forward to a continued partnership not only with the government but with our fellow community colleagues.

Mr O'Connor: I appreciate your comments. I think they really hold together quite well and we have heard about the personal support services—I'm trying to be quick here because you did actually make quite a few good suggestions.

In the regulations section, you referred to the volunteers. Could you point to a spot where you thought maybe we should incorporate some of what you suggest into the body of the bill, or do you think we should just enhance the regulation section that you pointed out to us? Page 8 of your brief.

Ms Bergman: They believe that the long-term management in regulation 11 should be expanded in that

area to include all of the recruitment, training, scheduling, supervision, retention, recognition—

Mr O'Connor: Within that section.

Ms Bergman: Yes, within that section.

Mrs Sullivan: I'm interested in the point you make with respect to the separation of homemaking and personal support services. My understanding is that the reason they are separated in the bill is to allow fees for some services and no fees for other services. Clearly, the same individual could be delivering those services. I'm wondering if you've considered how your member agencies or your workers would separate costs—it would make it accounting—and what the government's intention is with respect to how those services for which fees would have to be paid would be accounted for if the person delivering them is doing some things out of one category and other things out of another category.

Ms Bergman: We believe that would be an administrative nightmare and there's no other word for it. We believe there has to be a clarification of what is essential, and essential in remaining at home is not only personal care, but it's some of the upkeep of your home. If it's not upkept and you get maggots and cockroaches and whatever, you cannot live at home; you will eventually be institutionalized. The government needs to readdress what is essential and should be paid for by our government.

Our IHP program is currently providing personal support and the other services as well along with it. To go back retroactively, I think, and tell some of our IHP clients, "Well, I'm sorry, now we'll pay for your bath, but we won't pay you for going to get the groceries or we won't pay for tidying up your apartment for that hour," administratively, that's going to be very difficult.

Mrs Sullivan: There's another issue that I want to ask about and it hasn't come up today. It's with respect to paying bills and doing banking. Many agencies, I know, are withdrawing from those services because of some of the liability questions that are associated with them. I wonder if you'd like to comment on whether in fact that should be a mandated part of service delivery.

Ms Bergman: Again, I'm addressing this as an OCSA board director, so I really don't know the response from that aspect. From my position as a homemaker manager, it is certainly part of our program. It is an essential part. If a person living in their own home does not have a family member or a close neighbour to go and pay their bills or do some banking for them—it has to be done and you cannot eliminate that need. It's a need so, yes, it has to be part of a service, but it also has to come under quality management guidelines. There have to be regulations or rules in place by the organization that say how money will be handled for a client, how much you are allowed to take to the store. There have to be guidelines in order to handle it appropriately.

The Chair: Members of the committee, that ends our hearings here in Thunder Bay. The committee stands adjourned until 9:30 tomorrow morning in Sault Ste Marie.

The committee adjourned at 1538.

CONTENTS

Monday 22 August 1994

Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,	
projet de loi 173, <i>M^{me} Grier</i>	S-1837
Ontario Nurses' Association, region 13	S-1837
Judy Tinnes, member, legislative committee	
Levina Collins, representative, volunteer group	
Linda Launderville, member	
St Joseph's Heritage	S-1841
Sister Bonnie Anne MacLellan, executive director	
St Joseph's Heritage, P.R. Cook Apartments	S-1846
Anne Bowd, manager, support services program	
Marie Jean, support services client	
St Joseph's Heritage, Alzheimer Day Centre	S-1848
Frances Adderley, manager	
Elizabeth Montgomery, care giver	
St Joseph's General Hospital	S-1851
Carl White, chief executive officer	
Association of Ontario Physicians and Dentists in Public Service, Thunder Bay region	S-1854
Dr Ruth Kajander, representative	
Victorian Order of Nurses, Thunder Bay and district branch	S-1858
Harriet Laudadio, executive director	
Donna Opie, director, home care program	
Comcare (Canada) Ltd	S-1862
Helen Berry, manager	
Canadian Red Cross Society, Ontario division, Thunder Bay and northwestern branches	S-1866
Sonia Prodanyk, chair, homemaker services committee, northwestern branch	
Prue Morton, chair, homemaker services committee, Thunder Bay	
Fran Ormiston, chair, homemaker services committee, Kenora-Keewatin	
Ontario Community Support Association, areas 13 and 14	S-1870
Karen Bergman, board member	

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- ***Chair / Président:** Beer, Charles (York-Mackenzie L)
- ***Acting Chair / Présidente suppléante:** McGuinty, Dalton (Ottawa South/-Sud L)
- Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- Carter, Jenny (Peterborough ND)
- Cunningham, Dianne (London North/-Nord PC)
- Hope, Randy R. (Chatham-Kent ND)
- *Martin, Tony (Sault Ste Marie ND)
- *O'Connor, Larry (Durham-York ND)
- *O'Neill, Yvonne (Ottawa-Rideau L)
- Owens, Stephen (Scarborough Centre ND)
- *Rizzo, Tony (Oakwood ND)
- *Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Haslam, Karen (Perth ND) for Ms Carter
 Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham
 Malkowski, Gary (York East/-Est ND) for Mr Hope
 Sullivan, Barbara (Halton Centre L) for Mr Eddy
 Wessenger, Paul (Simcoe Centre ND) for Mr Owens

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Gardner, Dr Bob, assistant director, Legislative Research Service

CHRON
7012
-577

Government
Publications



S-63

S-63

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Tuesday 23 August 1994

Journal des débats (Hansard)

Mardi 23 août 1994

Standing committee on
social development



Comité permanent des
affaires sociales

Long-Term Care Act, 1994

Loi de 1994 sur les soins
de longue durée

Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944-1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Tuesday 23 August 1994

Mardi 23 août 1994

The committee met at 0931 in the Holiday Inn, Sault Ste Marie.

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

CANADIAN RED CROSS SOCIETY,
ONTARIO DIVISION,
SAULT STE MARIE BRANCH

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. The standing committee on social development is in session. We're delighted to be here in Sault Ste Marie for our hearings today. We have a very full schedule, so without further ado I would invite the representatives from the Canadian Red Cross Society, Sault Ste Marie branch, to come forward and make their presentation. As you come forward, we have a copy of the submission and welcome you to the committee. If you'd be good enough just to introduce yourselves for members of the committee, then go ahead.

Ms Shelley McEachern: Good morning. My name is Shelley McEachern and I'm with the Canadian Red Cross Society as a volunteer.

Ms Sue Irvine: Good morning. My name is Sue Irvine and I'm also with the Red Cross Society. I'm from Timmins. This morning Shelley and I will be speaking on behalf of northeastern Ontario.

I'm a Red Cross volunteer from Timmins and I am a registered nurse by profession. Presently, I work in the education department in our local hospital. I have been involved with the Red Cross since the early 1980s. Initially, I became involved with the Red Cross through teaching in home support level II and level III programs. It is through this experience that I became aware of the valuable contributions that the Red Cross provides in my community. I presently sit as a member of the local Timmins and district Red Cross homemaker committee, and I also serve as the northeastern homemaker representative on the provincial homemaker committee. Having lived and worked all my life in northeastern Ontario, I would like today to share with you what the Red Cross means to the people of northeastern Ontario.

Northeastern Ontario is a vast geographical area. Most of the communities are isolated from each other, far from urban centres, difficult, and sometimes impossible, to access in the winter. Transportation is often very limited and can also be very expensive.

Red Cross has been providing in-home services in this

region for nearly four decades. Homemaker and home support services are provided by four main branches: Sudbury, North Bay, Timmins and Sault Ste Marie. From these main branches, Red Cross provides services to areas such as White River, Dubreuilville, Wawa, Elliot Lake, Blind River, Thessalon, Smooth Rock Falls, Cochrane, Kapuskasing, Hearst, Iroquois Falls, Matheson, Hornepayne and their surrounding areas. In all of these communities, except for Sudbury and North Bay, Red Cross is the only provider of homemaker services. Other services that the Red Cross provides include Meals on Wheels, Wheels to Meals, adult day care, Alzheimer respite, home maintenance, transportation, home health care equipment services, friendly visiting, telephone assurance, and fun and fitness programs.

As community needs have been identified, Red Cross has historically expanded their services. Our ability to readily respond to meet local community needs and to provide high-quality service has reinforced our reputation as a credible service provider. Within northeastern Ontario there has been a lot of collaboration and cooperation between service providers. Duplication of services has been kept to a minimum. A good example of this collaboration is the Alzheimer respite and home support program for the elderly in Sault Ste Marie. These programs could have been spun off, creating new organizations, but instead it was decided to build on the existing Red Cross service.

The development of suboffices has enabled Red Cross to provide a cost-effective and efficient way of delivering services in this area while maintaining provincial standards. Administrative functions are supported from the main branch office while service delivery and supervisory functions are delivered in the suboffices. This enables us to maintain a local presence in these communities. In these areas we hire local people, we are able to be more responsive to community needs and we are able to mobilize local volunteer support. However, Red Cross has made a commitment to provide services in these areas.

Each month in northeastern Ontario, Red Cross provides almost 50,000 hours of homemaking service to over 2,500 clients, utilizing over 500 staff. Hundreds of volunteers are involved in providing other home support services. For example, last year in Timmins over 100 volunteers provided 8,000 meals to 122 clients, and 800 volunteer hours were needed to handle over 32,000 calls to the telephone assurance program in Timmins.

I would like to take this opportunity to highlight a few examples of the Red Cross responding to community needs with the assistance of our vast network of dedi-

cated volunteers and staff. The following two examples demonstrate the excellent reputation and support the Red Cross enjoys in the community it serves.

The first one: A local Red Cross transportation program in a small community 50 kilometres from Sudbury is a fine example of Red Cross voluntarism in action. Red Cross has been providing transportation services to this community for the past five years. Volunteers and staff are from this community, including the mayor, who is the chairperson of the Red Cross transportation committee. During the five years volunteers have driven the equivalent of six times around the world. More than half the volunteer drivers are seniors.

One particular driver—in fact, she has driven the most kilometres—serves on the local Red Cross transportation committee. Every year she makes a hand-hooked rug to be raffled off for fund-raising to help this program and then also helps with the sale of the tickets. This volunteer was also a client of the service a few years ago. I wonder if she will continue to be such a good volunteer for an MSA 50 kilometres away.

This particular volunteer is also a member of a seniors' club. She became involved with the Red Cross due to the Red Cross linkage with the seniors' club. A local mining company had donated a building to the seniors' club and the club, in turn, offered free office space for the Red Cross.

The main branch office in Sudbury provides administrative support to this program. Red Cross, Ontario division, supports this initiative through the development of provincial programs for recruitment, orientation and training of volunteers and volunteer recognition programs. It also provides support to the volunteers, helping them to provide a high-quality, standardized service.

The second example: Five years ago, Red Cross started a gardening program in Timmins. A gentleman who was a Rotarian and former market gardener had an innovative idea that would allow him to garden despite his infirmities. He created what is now known as the tire garden. By piling discarded truck tires and filling them with earth, he was able to create garden plots that were elevated. He wanted to share his garden with other seniors. Having received Meals on Wheels from the Red Cross, he approached the local branch to ask if seniors could visit his farm and help him tend his tire garden.

Beginning in late spring, volunteers bring seniors to the garden twice a week. During their visit, volunteers assist the seniors in gardening activities and prepare a picnic lunch. The local food stores donate the refreshments. The Rotary Club has donated the picnic tables, barbecues and lawn chairs. They have installed portable toilets and also donate all of the seeds yearly.

The program has been so successful that last year it expanded to other northern Ontario communities through funds made available from the government. This year it looks like we are headed for a bumper crop.

We would now like to share with you two examples of how the Red Cross homemaking services can make a difference in the lives of their clients as well.

The first one is a female client in her late twenties.

She's a quadriplegic resulting from a motor vehicle accident. At the time of her accident she had three small children under the age of five. Her husband, who works in the lumbering industry, is away 12 hours per day. She lives in a remote area 20 kilometres from the small northern town in which one of our suboffices is located. She has been a client since 1985.

Red Cross provides services 12 hours a day, five days a week. The Red Cross homemaker provides child care, household management and personal care to this client. Road and weather conditions are an ongoing challenge to providing services to this family because of her location. Our service has allowed this family to continue to function.

The second example is the Red Cross providing services to an AIDS victim who is terminally ill. He was one of our first AIDS clients in 1988. At that time he told us that we were all learning about AIDS and he didn't know what he would do or how he would get through each day without his homemaker. She was with him till the day of his death. His wish to die at home was made possible because of this Red Cross homemaker.

0940

Although we support the principles underlying the reform and the purposes as outlined in Bill 173, we are not able to support the creation of multiservice agencies, or MSAs, as described in the act. We are concerned that the proposed model appears to discard a system with proven strengths, replacing it with complex and highly bureaucratic organizational structures, this despite input that has demonstrated such monopolistic organizations do not work. Rather, they lead to a two-tiered system.

In the northeast, organizations like VON, home care program and the Red Cross have a long history of collaborative relations. These organizations provide excellent services. We should be building on this proven expertise and not discarding it.

We are very concerned that clients are unaware of the impact that this legislation will have on agencies that have been providing services to them over the past several decades. The results of regular surveys of client satisfaction conducted by the Red Cross indicate a high level of satisfaction with our service. If the legislation is to be proclaimed without amendment, the Red Cross and many similar agencies will be forced out of business. If this is to be the case, the government has an obligation to inform the public.

Our quality service comes from the partnership between our volunteers and staff who are committed to our vision, to our mission and to our fundamental principles. We feel the legislation will have a very damaging impact on our volunteers' role within the Red Cross. We are a volunteer-based organization. Our wide range of programs and services provides volunteers with diverse backgrounds and interests a variety of meaningful opportunities to participate in the work of the society.

The legislation, as it is currently drafted, precludes the Red Cross, its regions, branches or programs from becoming an MSA or providing services as part of an MSA. The Red Cross is committed to meeting the needs

of the vulnerable members of our communities, building on the range of services that we have developed over the last 75 years.

The Ontario division of The Canadian Red Cross Society is not a distinct organization but is a part of a national incorporated entity, the Canadian Red Cross Society, which in turn is part of the International Red Cross and Red Crescent Movement. The Red Cross has a long history of effective and efficient services throughout the world.

The legislation requires that each MSA be incorporated under Ontario legislation. Each MSA must have its own board of governors selected in accordance with the act. These requirements are incompatible with the fundamental principles and corporate structure of the Canadian Red Cross Society.

In summary, Bill 173 specifically excludes the Red Cross from providing in-home services to the residents of Ontario. It would be a tragedy if our present system was dismantled and replaced by a large bureaucracy. Can the government afford to disregard 75 years of credible, accountable and fiscally responsible services?

Thank you. Shelley McEachern will now comment on specific aspects of the bill.

Ms McEachern: My name is Shelley McEachern. I'm a volunteer with The Canadian Red Cross Society. In particular, I'm chair of the Sault Ste Marie homemaker committee. I became involved with the Red Cross as a result of my keen interest in community health care and, in particular, the health care of the elderly.

I am a nurse by profession and currently the director of care of a long-term care facility. As a result of my work experience, I have encountered several individuals who because of the Red Cross were able to postpone institutionalization. This specific experience, combined with the good work and reputation the Red Cross maintains in this community, led me to the society when I choose to volunteer my time and talents.

I am also the president of the Alzheimer Association of Ontario. Originally, my involvement with the Red Cross was through the development of a respite program for people afflicted with Alzheimer disease. I continue to be a liaison between the Red Cross and the local Alzheimer society. Our local Alzheimer society supported training homemakers to a level that would support in-home respite service. The Alzheimer society's commitment to training is ongoing. The training has given homemakers the competence to provide service to clients with Alzheimer disease. With the competence has come the confidence to work with this challenging population.

We welcome the opportunity to comment on Bill 173. There are several issues of particular interest or concern to us that we will specifically address in this submission.

The Red Cross specifically recommends that three sections of the legislation be amended. We believe that these amendments would in no way adversely affect the purposes of the act; rather, they would enhance flexibility and allow the existing strengths of the system to be augmented.

Part II, section 2, paragraphs 3 to 4: This section

designates the community services which are to be provided by the MSAs. The bill describes four categories for these services and specifically delineates the specific services that fall under each category. The bill describes community support services, homemaking services, personal support services and professional services.

The basic premise underlying the breakdown appears to be to separate personal care, or "hands-on" care, of the person versus non-personal care and services. We have two concerns with this aspect of the legislation.

The division between homemaking and personal support services is inconsistent with current practice and emerging future trends. It has taken concentrated effort over the past few years to erase the misapprehension that homemakers are nothing but cleaning ladies, subservient to the other members of the health care team.

The homemaker has begun to achieve genuine recognition as a valued member of the health care team. The wording of the legislation significantly devalues the role of the homemaker and may lead to a reversal of the growing appreciation of the homemaker as an integral member of the health care team.

The separation of personal care versus non-personal care and services appears to be impractical and may create serious difficulties for the management of service delivery. The delineation of services between the two categories is inconsistent with the way the services are usually delivered into the client's home. Many functions routinely provided by the homemakers cross the boundaries between what the legislation classifies as "homemaker" and that called "personal support."

We are also very concerned that the uncertainty arising from the reform has created significant anxiety among our staff. One of our highest priorities is to look after the interests of the over 6,000 individuals, mostly women, whom we employ.

0950

Recommendation: The Red Cross recommends that the legislation be reworded to eliminate the specific reference to, and categorization of, community services; that the regulations to the act be used to define those services to be provided by an MSA; and that the act and the regulations respect interrelationships between services.

Part VI, section 13: This section stipulates that an MSA may not spend more than 20% of its budget to purchase community services. The Red Cross recognizes that the government has committed to moving away from the brokerage system. In our opinion, the problem with the current delivery system is not brokerage but lack of coordination and poor access. We feel that in many situations brokerage can be an efficient system for service delivery.

Presently, many services are provided effectively and efficiently by a number of established agencies. These agencies have long histories of service to their communities. They are often supported and governed by volunteers who are part of that community. Stable relationships have been developed between provider agencies, care givers and the individuals they serve. Rather than replacing the existing system, efforts should be made to

improve coordination and enhance efficiencies. One example would be to contract with a provider agency for blocks of service rather than the less efficient client-by-client contracting that now occurs.

In most communities, services are provided by several provider agencies. Each agency must retain a critical volume of service to remain economically viable. The volume of services must be adequate to support the operation if the agency is to stay in business. Also, the volume must be adequate to allow the development and maintenance of an infrastructure that supports quality and risk management. Where MSAs are declared, and as they move towards assuming 80% of a given service, the critical volume necessary for the alternative provider to exist will be lost. The MSA will then be forced to assume responsibility for providing service before it is ready. Alternatively, clients will be placed on waiting lists. The Red Cross is very concerned that clients may face waiting lists, a decline in quality of service, or limited or no choice. Those who wish to purchase services outside the MSA will be unable to do so if there are no alternative providers in the community.

In may remote and sparsely populated communities, like northeast Ontario, the Red Cross is the sole agency willing to provide service. Our corporate structure and fundamental principles preclude us from providing services within the proposed MSA structure. We are concerned that if the MSAs are imposed in these areas, the declining volume of service allocated to us, in combination with increasing deficits due to the high costs associated with travel, will ultimately force us out of business. This will leave many clients without service. Where the local MSA plans to assume responsibility for directly providing the necessary services to these clients, accommodation will have to be made to offset the deficit inherent in servicing these areas of the province.

Recommendation: The Red Cross recommends that the legislation be reworded to remove limits on the amount of service that an MSA may purchase and that the legislation enable each community to choose the best service delivery model or models and optimum mix of provider agencies to meet the needs of its residents.

Part VI, section 15: This section says that MSAs have just four years to comply with all the provisions of the legislation. Under the tight structures of this draft legislation, communities will not have the flexibility to identify and implement the models of service delivery that best suit their needs.

Recommendation: The Red Cross recommends that the legislation be reworded to eliminate the requirement for MSAs to comply with the provisions of the act within four years after being designated as MSAs and that the legislation enable each community to develop and implement the model for community-based long-term care that best meets its unique needs and its culture.

The enormity of the impact of this legislation has not been fully explained to the consumer. Government speaks of expanding services to underserved areas, yet there will be no additional resources made available. Red Cross has been working collaboratively with other service providers to maximize the use of available resources. In

northeastern Ontario, duplication of service providers is not an issue. The legislation must permit agencies such as the Red Cross to continue to provide excellent and necessary services to the residents of the province. Thank you.

The Chair: Thank you very much for a very full brief. I want to permit a question from each caucus, but I would ask for just one question and if you could keep it brief, because of our time constraints.

Mr Tony Martin (Sault Ste Marie): Thank you. I wanted to first say welcome to all of my colleagues from Queen's Park to my home town. There's a song, I think, that goes like that. It's nice that we were able to come up and hear from the folks in Sault Ste Marie and area. I'm looking forward to hearing from everybody today so that I can be better educated on this issue and understand what the concerns are.

I want to thank the Red Cross for coming forward. Certainly there's no doubt but that you do tremendous work. The services that you provide across the north are certainly a major part of what actually, before I started this process, I thought was your work, which is in the area of blood supply. Every time there's a major crisis in the world, the Red Cross is always there. I'm assuming you're not saying today that if you lose some of your ground in this whole process, the Red Cross is going to disappear. It's been around for a long time. I'm sure it'll be around for quite a time to come.

You know that the reason for this reform, which has been called for by people for over 10 years now, is to provide equity of service and access across the province, particularly in the areas that you spoke of today, the smaller, remote areas that need the same supports that the larger centres need and that we want to in fact build on the good things that you and other people have been doing in this area.

Actually, you had said in your last paragraph that there wouldn't be any more money. We have increased the funding to long-term care by 54% in the last couple of years, and there is a plan to increase it even more, so that those services can be provided. We certainly are also looking at a great degree of local control and direction.

1000

My question to you is, first of all, do you belong to the Ontario Community Support Association? I think you do. We had somebody present yesterday who was an active participant in that organization. Are you aware of the call that they made for an MSA? Are you involved in the local planning consultation process in Sault Ste Marie and area?

Ms McEachern: Yes, we are a member and we are involved in the local planning process that is ongoing. There are a number of community agencies currently meeting to discuss the development of the MSA within our area and Red Cross has, through its staff and volunteers, participated in that process. The Red Cross homemaker committee in the Sault has discussed that issue over the summer and are willing to speak with any of the other agencies in the development of these MSAs.

Mrs Barbara Sullivan (Halton Centre): I'd just like to correct the record. The community support association has not supported the MSA. In fact, the Red Cross comprises 50% of that organization and they're certainly not in favour of the MSA model as proposed.

I want to indicate to you that our party will be putting amendments forward with respect to the 20% limit and the transition time, but I also want to ask the ministry some questions with respect to your brief.

You've indicated how the Red Cross has adapted its infrastructure to meet the needs of distance and geography of the north and to reach people in remote areas, and you have spoken with respect to the deficits that are associated on the operating side of your budgets with ensuring that services are provided in those remote areas.

I would be very interested in knowing how the ministry will take into account, since it's going to put you out of business in homemaking and home care services, the costs of what in your organization are deficits, of covering those remote areas, which clearly in your organization are made up through other fund-raising vehicles and other parts of your budget.

How will the ministry and what steps has the ministry taken to ensure that those deficits are covered and that the full budget costs that are held by the Red Cross are in fact met through the MSA? What guarantees will you put into place?

Mr Paul Wessenger (Simcoe Centre): If I might just comment on that, I think it's fair to say it's anticipated, with the MSA, that you're going to have administrative savings with respect to the functions. So you're going to have a more efficient delivery of service, and we do not anticipate you would have deficits occur under the MSA situation.

I'm not aware, I must admit, of the extent to which there are deficits in the home care program here. It would be interesting to have that information, and maybe we could have the Red Cross indicate, in its various branches, what deficits it has in running its home care programs. That might be of assistance to the committee.

The Chair: Is there any comment you want to make on that at this time?

Ms McEachern: No, other than to say that I'm sure that information is available and that we'll forward it to the committee.

Mr Cameron Jackson (Burlington South): I appreciate receiving your brief. I was here when we were doing Bill 101 and it was unique to the presentations in northern Ontario that they sort of gave us little insights into the extended world of support services. They used the occasion of Bill 101 to talk about the future of Bill 173, and I appreciate that because that added to my education.

Now I find myself, a year and a bit later, back here in northern Ontario and I see an absolute shift on the part of the government in terms of the model. Your concerns which you expressed a year and a bit ago are now coming forward, but they're coming forward in a more desperate fashion.

My question to you is: Given that you thought you were working with a brokerage model, which was the

genesis of how services were developed in the north—you're now into an assimilation, a monopoly model, which is going to, by your own words, wipe out your agency—would you, for the record, indicate support if the Conservative Party were to put in an amendment that allows for the brokerage model to be maintained in northern Ontario because of the unique nature of the service which is already established that we don't wish to dismantle; and secondly, that it respects the absolute unique challenges of distance and access, which you've been doing a superb job of? I frankly don't trust government to do a better job than what you've been doing.

Would you support an amendment which, although it differentiates between southern and northern Ontario, it's clear that this legislation was drafted in Toronto, made in Toronto and it's a Toronto-centred solution for a problem the north doesn't have?

Ms McEachern: Well, your comments are certainly appropriate. That's exactly our feeling, so yes, I think we would support that sort of a motion.

Mr Jackson: Thank you very much.

The Chair: Thank you for coming before the committee this morning.

Mr Martin: Mr Chair, may I, while they're in transit, make—

The Chair: Let me just call the next witness and then I'll recognize you, Mr Martin.

Mr Martin: Okay.

The Chair: Thank you. The Ontario March of Dimes, Sault Ste Marie branch, if the representative would come forward.

Mr Martin: I'd just like to, on a point of privilege, clear the record here. Mrs Sullivan had said that the OCSA did not in fact support MSAs. There was a woman who came before us yesterday and I have her presentation here, and very clearly in here the OCSA is saying that it supports MSA models and indeed alternate MSA models across the province in this exercise. I just want to make sure that the record is correct and that my comments are not refuted in any way.

Interjections.

The Chair: Order, please, order.

Mr Martin: I'm just asking the opposition to read the briefs, Mr Chair.

The Chair: That's fine. The point has been made. We are here this morning to listen to the witnesses and we'll go ahead with that.

ONTARIO MARCH OF DIMES, SAULT STE MARIE REGIONAL OFFICE

The Chair: Welcome to the committee. Every now and then members get a little itchy. I want to welcome you to the committee. If you'd be good enough to introduce yourself; we have a copy of your submission in front of us. Welcome.

Ms Valerie Scarfone: My name is Valerie Scarfone and I'm the independent living manager for the Ontario March of Dimes in Sault Ste Marie. I'll try to summarize our brief.

The Ontario March of Dimes commends the govern-

ment of Ontario for its efforts to reform long-term care services in this province and to implement the multi-service agency concept.

Ontario March of Dimes has a vital interest in the reform process. The mission statement in our organization is "to assist adults with physical disabilities to lead meaningful and dignified lives." We accomplish our mission through the provision of a variety of programs and services. Our largest program is the attendant services program, which provides assistance with activities of daily living to enable adults with physical disabilities to live in their own homes.

Locally, the Ontario March of Dimes operates a support service living unit program for 12 individuals in Sault Ste Marie. This program provides 10,504 hours of service annually to 12 individuals, with a budget of \$451,320. Three outreach attendant care programs operate throughout the district of Algoma. Together, these programs provide a combined total of 17,069 hours of service each year to 55 individuals, with a budget of \$545,183.

Both the outreach attendant services programs and the support service living units have extensive waiting lists in this community and in the district. Waiting lists are for both people wanting an increase in the current level of service they receive and for initial service. In the district there are approximately 40 people waiting for attendant services.

For the majority of individuals receiving outreach attendant service, there is a desperate need for respite services for their family members. The availability of respite services is essential to enable people with disabilities to remain in their own homes. Currently, in the Algoma district there are no in-home respite services for our consumers, adults with physical disabilities, and for their families.

In the many public consultations on long-term care reform held over the last few years, the Ontario March of Dimes has encouraged its consumers, volunteers and staff members to express their ideas about this reform. This paper summarizes the position of Ontario March of Dimes on long-term care.

Ontario March of Dimes believes that the key principle of long-term care reform should be guaranteed access to essential long-term care services required by persons with physical disabilities and older people to live independently in the community. Long-term care reform must also retain choice for consumers in accessing services. Ontario March of Dimes strongly recommends that consumers maintain the option of accessing attendant services directly or through the multiservice agency. Competition in service provision will ensure that consumers benefit from increased quality through a greater service accountability and thus can truly act as consumers, choosing the service provider that best meets their needs.

Consumers with disabilities have clearly stated that they do not wish to have a medically oriented service philosophy in making important decisions in their lives. They believe that this philosophy will only perpetuate the notion of disability as illness and serve to promote dependency rather than independence. The non-medical,

consumer-directed nature of attendant services should therefore be protected, while ensuring choice with respect to where and by whom the service is provided.

Service provision and assessment:

Prior to the shift of funding from institutions to community-based services, Ontario March of Dimes urges that there be equitable local resources developed across Ontario to ensure that essential services such as homemaking, visiting nursing and attendant services are available in all parts of the province. Ontario March of Dimes believes that assessment and service provision should be separate to avoid potential conflicts of interest.

The multiservice agency staff should be trained to assess consumers in the broad context of their total wellbeing and independence and not just their medical needs. Consumers with disabilities should have input in establishing service and administrative standards for community support services to ensure that they meet their needs and not just those of seniors. As well, the boards of multiservice agencies should have a strong component of participation from consumers with disabilities.

1010

We oppose user fees for long-term care services. Many of these services are essential to allowing persons with disabilities to maintain independence.

Ontario March of Dimes supports the broad range of services provided by long-term care. However, the ministries of Health and Community and Social Services have made reference to the fact that personal support and professional services would be "generic" in nature. The concept of generic services should be carefully considered to avoid opting for the least expensive option rather than the best quality and most appropriate service. Certain groups have developed specialized skills for servicing client groups while fostering integration. These skills, along with the options they represent, should not be sacrificed in the pursuit of a generic service provider.

Life skills training:

In addition to the need for greater expansion and accessibility to community support services, there is a very real need for funding for life skills training programs for those moving to supportive housing projects from chronic care or nursing home settings. Life skills training not only helps individuals to achieve successful independent living but also reduced costs as consumers lessen their dependency on attendant care services. This is especially true for Sault Ste Marie. When we're looking at people for our support service living units, we often refer them to either Sudbury or Toronto for life skills as there's no formal program here.

Appeal process:

There should be a simple and expedient process in place for consumers and agencies to appeal decisions of the multiservice agencies. Services should continue while a decision is being appealed.

Funding of long-term care:

(1) Core services: Ontario March of Dimes believes that long-term care reform should proceed in the context of protecting Canada's universal health care system, restructuring services for greater effectiveness and

efficiency and shifting to a model of wellness and prevention.

We strongly recommend that funding also be provided for assistive devices and home modifications which allow individuals to continue living in their own homes.

Governments should ensure that consumers are not denied benefit of coverage for items such as incontinence supplies by virtue of their leaving the home care nursing case load to receive services from an attendant services program.

(2) Support services: We are concerned that the possible transfer of funding for outreach attendant services to the multiservice agencies could jeopardize the smaller outreach programs. Many of these programs offer services which are unique and respond to consumer need in innovative ways. We believe the province should continue to directly fund the support service living units and the outreach attendant services programs. A common problem experienced by consumers of support services is rigidity of provision. Due to funding restrictions, many service providers limit the availability of attendant care on weekends or nights. This restriction severely limits opportunities for people to live independently.

We recommend that the government provide funding for agencies to provide extended service and make it mandatory for all service providers to make this available. Extended service should also be offered in the workplace, school and recreational settings to ensure that persons with disabilities are not restricted from pursuing opportunities in these areas.

As well, volunteerism as an integral part of attendant services programs requires a financial commitment on the part of the government. While volunteers should not replace staff, they can serve to enhance programs and contribute to extending independence and fostering integration.

(3) Direct funding: Ontario March of Dimes believes that direct funding to consumers with disabilities for attendant services should be a central option within the reformed long-term care system. The concept of direct funding would give consumers with disabilities confidence, experience in handling finances and managing people and help them to achieve greater independence by controlling decisions that affect their lives.

Supportive housing:

As the long-term care reform process promotes community-based care in the home, the basic underlying assumption is that the recipient of support services has a home.

Ontario March of Dimes believes that supportive housing should be encouraged in the widest possible range of housing types and locations. Our 13 years of experience in operating support service living units demonstrates that the support service living unit is a successful model which merits expansion.

We therefore strongly recommend that the Ministry of Housing and municipalities collaborate to provide accessible affordable housing units in the province and to encourage non-profit organizations to sponsor the support service living unit projects.

In conclusion, the Ontario March of Dimes encourages the Ontario government to enact Bill 173 in order to proceed with long-term care reform.

However, we believe that the points raised in this paper should be carefully considered prior to implementing the reformed system. Further consultation with consumers, service providers and community organizations is essential in order to develop an effective and efficient long-term care system in Ontario. We are committed to working with the government to ensure that the reformed long-term care system respects the autonomy of persons with disabilities in choosing services which most appropriately meet their needs.

Mrs Barbara Sullivan: Thank you for your brief. I'm interested in two questions that you have raised. The first one is with respect to the life skills training. I am wondering if the ministry could respond by indicating if life skills training is included under the personal support services in the mandatory basket. That would be subsection 2(6), paragraph 4, "Training a person to carry out or assist with any of the activities referred to in paragraphs 1 and 2," which would include "routine personal activities of living."

The other question, also of the ministry, is: What steps will be taken with respect to funding the outreach attendant services and the support service living units as a result of long-term care reform? How will that fold into the MSA?

The Chair: The parliamentary assistant.

Mr Wessinger: I'm going to refer part of that question to the ministry. Perhaps I'll just indicate that the SSLUs will continue to be funded outside of the MSA model and I understand, with respect to the attendant care, it's going to be a consumer decision with respect to how those services are delivered. The rest of the questions I'll refer to Mr Quirt.

Mr Geoff Quirt: As the parliamentary assistant has indicated, consumers of attendant care outreach services in each community will have the option of having their attendant care outreach program funded separately, as it is now, by the province directly, or, if they choose, they could opt to receive their services from the multiservice agency.

With respect to life skills training, yes, that is the kind of thing that section of the bill refers to. In addition to that, with the support service living unit program, it's quite possible for us to include, in the funding that goes to the SSLU, funding to support training activities if that's a necessary part of providing the support needed to assist someone in transition from a chronic hospital to an even more independent lifestyle than a support service living unit.

Presumably, if clients here have to go elsewhere for that, it would be worthwhile to explore with the DHCs whether they would recommend to the minister that a proposal for that type of training be funded.

Mr Jim Wilson (Simcoe West): Thank you, Ms Scarfone, for your presentation. I was just wondering if you had any further points to make about the MSA model that's proposed, envisioned in this actual piece of legisla-

tion. Do you have any concerns about the fact that 80% of the services will now be delivered by one agency? That is the twist that we've encountered along the road of long-term care reform. We've gone past one-stop shopping and one-stop access and one phone number to an actual monopolistic model. Has the Ontario March of Dimes addressed that? Because, of course, the government will simply take your sentences in this brief, as it did with the Ontario Community Support Association, and say, "Well, March of Dimes is fully supportive of the MSA model," so here's an opportunity to express any concerns you might have.

Ms Scarfone: The concern we have is that we believe that persons with disabilities should have the option of accessing attendant services outside of the multiservice agency.

Mr Jim Wilson: As long as there's that flexibility, you're fine with it.

Ms Scarfone: That's right.

Mr Jim Wilson: Okay.

Mr Martin: My question was answered. The answer was given. I again want to thank you for the tremendous work that the March of Dimes is doing in this community and continues to do. We don't get a chance often enough to do that publicly. Of course, this legislation is designed to build on that good work and to bring some coordination and cooperation to the picture.

1020

Certainly, your reference to consumer rights and things being driven by consumers, which I know is a guiding principle of how you folks operate, is also built in here. There is an appeal process and there's in fact a bill of rights that comes with this that will ensure that people have every opportunity to contest and to give input. The coordinating committee itself will be locally driven, elected by local people, and will have a high component of consumer presence there.

Given that the supportive housing piece is outside of this, just how much of what you do then will be affected by this new MSA piece that's beginning to roll out, and are you part of the local process that's pulling all of this together?

Ms Scarfone: Half of our attendant services program is outreach services, so half of our programs in this area would be affected by the multiservice agency. As far as my involvement in the planning process, I serve on the district health council long-term care committee, so I'm quite involved in the planning.

SAULT STE MARIE GENERAL AND PLUMMER MEMORIAL PUBLIC HOSPITALS

The Chair: I then call on the representatives from the Sault Ste Marie General Hospital. Would you be good enough to come forward. We have received a copy of your brief, and once you're settled, if you would be good enough just to introduce yourselves and then please go ahead.

Perhaps I might just indicate to committee members as you're getting ready, the witnesses after this presentation will be from the Victorian Order of Nurses and then the final witness for this morning will be from the Algoma

District Health Council, so there's a change from what is on your program.

Mr Manu Malkani: Thank you for the opportunity to appear before your committee today. My name is Manu Malkani and I'm the president and CEO of the two hospitals in Sault Ste Marie: the Sault Ste Marie General Hospital and the Plummer Memorial Public Hospital. With me are Mrs Laurie Walton, who is the director of our ambulatory and community services at the two hospitals combined, and Mrs Johanne Messier-Mann, the manager of our long-term services, palliative care and psychogeriatrics.

Again, all three of us represent both hospitals together. Laurie and Johanne will be making the bulk of our presentation today. I would like to take a few minutes simply to give you some background information about the organizations which we represent.

Both of our hospitals in Sault Ste Marie have a very long history of serving this community. The general hospital was founded 98 years ago by the Grey Sisters of the Immaculate Conception and the Plummer Memorial Public Hospital was founded 77 years ago.

Since the early 1980s, both of our hospitals have been engaged in a program of rationalization of services. In the early part of the 1980s, most of our efforts were focused on the rationalization of clinical programs, programs such as mental health, oncology, obstetrics, those kinds of programs. But more recently, in the last 18 months, we have come together even more closely in a very innovative partnership which provides for joint or shared governance of our two hospitals along with a single or common management and medical staff.

All of this has been driven by the initiative of our volunteer boards of directors, whose goal has been to eliminate all unnecessary duplication in our services while yet maintaining the history and tradition and independence of each organization. Our partnership we believe is the first such relationship between a Catholic and a public hospital, certainly in Ontario and perhaps even in the country, and we are very proud of what we have achieved by working together voluntarily with our staff, with our unions, with the representatives in our community, all for the good of the community.

I will not detail for you what these accomplishments are, although Mr Tony Martin on your committee is intimately familiar with all of these and in fact has been a very strong supporter of our efforts. I just want to make the point, because I think it's very key to the rest of our presentation, that all of this that we have achieved between our hospitals, while we have cooperation by way of innovative arrangements to deal with common problems, has been a result of the effort of volunteers working together within a framework of enabling legislation. I don't think any of this could have happened if we were working within a very tight prescribed kind of environment.

I'm going to stop with that and I will call on Johanne Messier-Mann to pick it up from here.

Mrs Johanne Messier-Mann: Our presentation will be brief and will be limited to the following three areas

of concern: These centre around the mandate of the multiservice agency; secondly, the use of the term "community-based" in the legislation; and thirdly, the functions of district health councils.

The mandate of multiservice agencies: The Sault Ste Marie General Hospital and Plummer Memorial Public Hospital support the objective of reform in the long-term care system. What we cannot support is the method by which the proposed legislation seeks to achieve this reform. The proposed legislation must focus clearly on the problem which it seems to fix.

The problem with long-term care now is access. We are not aware of any claims that the services, once accessed, are of poor quality.

The problem of access can quite easily be fixed by creating a central agency in each community to coordinate access to the host of non-institutionally based long-term care services. Such a coordinating service has been in existence in Sault Ste Marie and in many other communities for accessing institutionally based long-term care services and has worked quite well. Of course, I'm talking about our local placement coordination service.

Instead of such a simple and focused approach to solving a well-defined problem, the legislation seeks to alter other key features of our present long-term care delivery system, features which are not problems and indeed have served the communities very well. In so doing, we fear that the proposed legislation will create new problems such as:

- First of all, replace the rich heritage and traditions of individual provider agencies and organizations by a large impersonal and bureaucratic organization;

- Significantly dilute, if not eliminate, the commitment and participation of volunteers in the running of these organizations as well as the provision of services;

- Lose the fund-raising effort of volunteers, with the result that the system will require increased tax dollars or the system will have to manage with less dollars.

We recommend that the scope of the MSAs be limited to coordinating access to non-institutionally based long-term care service and not include the actual delivery, provision or evaluation of services.

I will now pass to Mrs Laurie Walton.

1030

Mrs Laurie Walton: I'd like to carry on and talk about the use of the term "community-based" in the legislation.

The legislation uses the terms "community-based" and "institutional" in a mutually exclusive way. The fact is, many hospitals in Ontario, and our two local hospitals, have provided a host of services outside of institutions, services such as primary care, supportive care, counselling and so on. We like to believe that our hospital and other institutions are as much a part of the community as are those agencies which provide services in the home.

Surely the purpose of legislation is not to set up boundaries within an established continuum of care. The negativity that exists in the very first statement of the purpose of the act, "To ensure that a wide range of

community services are available to people in their own homes and in other community settings so that alternatives to institutional care exist," reinforces the current fragmentation of access to services. We would recommend that "community-based services" be replaced by "non-institutionally-based services."

Our last point of concern has to do with the functions of the district health councils. Bill 173 enshrines DHCs in legislation and attempts to clarify their functions. However, we feel the redefined functions are not sufficiently clear concerning planning versus management. We would recommend, therefore, that the role of DHCs be clarified as being one of planning and advisory. Any change in this should be subject to a separate process of public debate and consultation.

Thank you for your attention, and we'd be pleased now to answer any questions.

Mr Jim Wilson: Thank you for a very good brief. As Health critic for the Ontario PC Party, I just want to tell you that there's nothing you've said that I or my caucus colleagues would have any disagreement with whatsoever.

I think you make an excellent point with respect to the terminology "community-based" versus "institutional services" or "institutional care" or whatever language, because as hospitals restructure, of course, you've been increasingly expanding the mandate and expanding the services into the community. We see that throughout the province, and you're to be congratulated for that. We will keep that in mind. That's a new suggestion to this committee and we'll certainly keep it under advisement with respect to amendments.

Very few presenters, as we've travelled the province, have talked about the new mandate or the new definition enshrining district health councils in legislation for the first time. I'm wondering if you could expand on your final comment here with respect to planning versus management by DHCs. What fears do you have? Because I am in full agreement that we don't really know what the management function is going to be and there could be some very scary things happening in this province with respect to the powers of the DHCs in the future.

Mrs Walton: That is our concern, that it is vague and it is sweeping. In particular, one of the functions, and I'll just quote, is "to perform any other duties assigned" to them by the minister. We have all of that tagged on—at least, we used to, in the good old days, have that tagged on to our job descriptions, and it meant all kinds of add-ons at any point in time in our careers. But surely the legislation should be a little more restrictive versus broad. This is quite vague, and I'll agree with you, there are some risks to it.

Mr Jim Wilson: In this area of the province, what has the general discussion been or has there been a consensus reached about what the role of DHCs should be? I refer to, for instance, the southwestern region of the province, where there's a move on for a regional government with respect to DHCs. What's the feeling here in the north?

Mr Malkani: We've enjoyed I believe a fairly healthy relationship with the DHC, with our DHC over

here. For our DHC, as all the other DHCs so far, their role has largely been planning, sort of district-wide planning, and an advisory role to the Minister of Health. Certainly our DHC has not gotten involved with the micromanagement of hospitals or other organizations. I can speak on behalf of our hospitals that that hasn't happened.

Our fear is what is likely to happen in the future if the terms of reference of the DHCs change. We see a certain ambiguity in the legislation. We may be putting two and two together and getting five, but we're not sure about that, and it is a caution that we want to leave with the committee that the role needs to be clarified rather than made blurred, and the clarification we would recommend ought to be in the direction of a planning and advisory role rather than one of management.

Mr Jim Wilson: Mr Chairman, I think we still have a bit of time. Could I just ask, with respect to the function of the MSAs, and I think you make a very good point on page 6 of your brief, in the public consultations that took place in the north during the long-term care reform process, was there an outcry from the people here that the MSA, in addition to coordinating services, should also be delivering the services? Because the government claims that is the case throughout the province and that's why this legislation has them delivering 80% of the services.

Mrs Walton: Initially, in the beginning stages of consultation, we were at the tables. We had lots of good discussion. I don't believe we understood the full implementation scheme, and I think that's where it is now unfolding and we have some questions regarding that. The total dismantling or destruction of community-based services as they exist right now is, again, very risky, particularly when we have no indication as to whether there will be the dollars or the total cost to do it. Certainly, when we look at the reform as it currently is unfolding in relation to long-term care facilities, we do have some distinct concerns regarding the cost and the implementation and the outcomes in relation to that reform.

Mr Martin: Again, I want to commend the hospital for the good work that it does in the areas it's involved in, and certainly the comment you make in your brief about access being the question here and not necessarily the quality of care, where it can be accessed. I think we have to recognize too that as our population ages, that whole question becomes even more acute and of greater concern. How do we deliver the kinds of services that are going to be required and how do we coordinate that so that we get the most mileage for every dollar that we put in and reduce duplication?

I wanted to say how, for example, the hospitals were an excellent example of that in this community. The coming together of the two hospitals was not something that was laid down from up above; it was a locally grown solution that we all participated in. It brought with it, though, some high degree of anxiety and fear, and in the end I think it's rolling out to be something that the community has wanted for about 10 or more years and is beginning to see the fruits of.

Certainly it's the intention of the government in this

legislation to allow local areas to decide for themselves what the MSA will look like, who it will include and how it will deliver services, all those kinds of things. And yes, that's pretty risky business, but I think, given the experience of the hospital restructuring that happened here and the fruits of that, it's worth it, don't you think?

Mrs Walton: If I could just add one other point, it was risky and it was something that the community wanted and it was necessary, and because of those reasons and because it was a community risk-taking for a community need, yes, we participated. Change at any point in time is very difficult, but I think you're hearing from a large majority of communities that they really don't want to take this risk within their community. Communities are being asked to solve the problem that's being imposed upon them.

Mr Martin: Actually, we're not hearing from large groups of communities that this is not something they want. Everybody wants the system reformed; they want improvements in the service. What we're hearing from are groups that are going to be directly affected, such as the groups that came into my office when the hospital restructuring was happening and who had some concerns because they were going to be directly affected. They were concerned about their jobs and where they fit in and all of that kind of thing, and it comes with this kind of a process.

So I would suggest to you that this community is involved in this process. There is a coordinating function happening, there are people meeting. As a matter of fact, there will be a group coming later who will talk a bit about the meetings that have been held. There have been a lot of people participating, and I think there is an indication that this community wants to be part of this change, wants to be able to take advantage of the new moneys that will flow to this. We've put \$850 million of new money in already and there's more coming.

Are you participating in that local planning process? Are you on that committee? Is your group on that committee?

Mrs Walton: I sit on the long-term care committee at district health council.

Mr Malkani: If I can just add to what Laurie said, and again using the restructuring of our hospital as an example, as you know, there is a model framework put forward by the Ministry of Health as to how communities should approach the restructuring exercise. Our approach in Sault Ste Marie was quite different from that. As you know as well, it has taken a lot of effort, and with a lot of help from you, to get the ministry to recognize that even though our approach may have been different from the model prescribed, the results are at least as good as, if not better than, what has been achieved in other communities.

1040

That really is the fundamental premise that we're putting forward: Leave room, in whatever we do, for locally made solutions. The problems may be common but we have a "made in Sault Ste Marie" solution over here, and we think it's best for us. It may not be best for

Chatham or somebody else. Similarly, with long-term reform as well, we agree with the objectives but we feel the framework being prescribed in the legislation is a bit overly prescriptive and might dampen some of the initiative at the local community level.

Mr Dalton McGuinty (Ottawa South): Thank you very much for a very good presentation. I think you have clearly articulated for us the essence of the problem, one of access, and the difficulties associated with the government's response to that problem.

If the hearings have emphasized anything for us, it's that there is a tremendous concern about what is going to happen to all of our volunteers working throughout the province in long-term care. I don't have any numbers on this but I would guess that at least 25% of the work that is presently being performed within the umbrella of long-term care is being done by volunteers. It may be much higher. I think on page 6 you've quite aptly highlighted some of the concerns connected with that.

I think you either have to be terribly naïve or wilfully blind, that volunteers who do work for individual organizations now are somehow going to transfer that loyalty to essentially a government agency. Human nature dictates that we are loyal to organizations because they have heritages, they have traditions, they have logos, they have mottos, they have uniforms, they have special missions. You contrast that with government today, and politicians and political institutions: We are suspect, we are treated with scepticism. That may not be right, that may not be healthy, but that happens to be the God's truth, as I see it.

The other problem with government is we're so concerned with political correctness that everything has to come out a shade of grey and we're dishing up pabulum. But people need distinctive features. That's what attracts them to the various volunteer organizations. I just have some very great concerns about what's going to happen to those volunteers, and I think it's simply unreasonable to expect that they will work for a multi-service agency. Would you care to comment?

Mrs Walton: I think you're absolutely correct, and my understanding of the brief that was put forward by the Catholic Health Association says it all in relation to volunteers. It's our tradition and our understanding that a lot of people are tied into the heritage and not necessarily the service. The people who come daily to the local hospitals—and they come twice a day; these people come around lunchtime to help feed patients and come back around supertime to again look after their relatives' needs—it's a tradition that they keep up for years and years. They do it because they have a close connection and they believe in the work we're doing and they're very grateful for having that service provided for their relative. So even at the direct care level we have volunteers who are coming because they believe in the organization and the values of that organization. Then at board level we have all kinds of volunteers, and even at DHC level you have all kinds of volunteers who are doing a lot of the work.

Mr Malkani: When we talk about the effect this might have on the volunteer effort, admittedly to some

extent we are crystal-balling, we are anticipating what may happen. I don't think that any changes are going to happen in a black-and-white fashion overnight, but I think there is a risk that over a period of time, as the perception gets reinforced that long-term care is now a government responsibility provided at taxpayers' expense and so on—rightly or wrongly, I think the model will foster that perception, and that will then begin to erode the extent of volunteerism.

Mr Wessinger: Thank you very much for your presentation. What would be certainly very enlightening to myself and I'm sure other members of the committee is if you would elaborate somewhat on your innovative partnership. Particularly, I'd like to know how you model your governance, the question of how the board works to make decisions, for instance, to give to management, and the extent to which you have your administration functions integrated in the new system. Lastly, I don't know whether you're in a position yet to indicate perhaps the level of efficiencies you've achieved in the sense of savings in the administrative functions that could go into service provision.

Mr Malkani: The model as we described it in our presentation is one which allows the two hospitals to carry on as separate corporations with two separate boards of directors, but at the governance level there is a new mechanism built in. Again, depending on whether you want me to get into details of that mechanism, let me just say for the time being that that mechanism binds both boards to a common approach on certain very key issues. The bylaws of the hospitals have been rewritten and approved by the Ministry of Health to allow that to happen.

The general hospital is a Catholic hospital, owned and operated by the Grey Sisters. The Plummer hospital is a public hospital. This arrangement came about through the recognition by the boards that although there were some differences between us, the similarities were greater than the differences and we needed to find a way to get the best of both worlds.

So we preserved the independence, we preserved the traditions, as we say, and the culture of each, yet we've come together through a binding mechanism. Neither board can "wiggle out," I guess is a crude term for it, of this commitment. We are bound to a common cause on a number of important things: decisions such as programs, who will do what, decisions about the budgets, decisions about hiring and firing the CEO. Those kinds of questions are pretty fundamental issues and all are bound to a common approach through that new joint mechanism.

Now, keep in mind that the boards don't cost any money; the boards are volunteers. So the fact that we have two boards, the academic question is, aren't we still duplicating things? Yes, we are, but to me that cup is half full rather than half empty, because we have twice as many community agents with their fingerprints on what's happening, rather than with a single board.

The expenses, the costs, are at the management level, at the operating level. Twelve months ago we had two CEOs and two VPs of finance and two directors of

housekeeping and two of everything else. Today we have one of each and we are on our way to having a single laundry, a single kitchen, a single emergency department. What we have achieved in the last 12 months has been a direct saving in our expenses, in our management and overhead and infrastructure costs, of approximately \$2 million on a budget of \$87 million. Those are cold, hard numbers. That is money that would otherwise have to be found elsewhere.

That's a thumbnail sketch of what we've done and how.

Mr Wessenger: That's very interesting. I appreciate that.

The Chair: Thank you all very much for coming before the committee this morning.

VICTORIAN ORDER OF NURSES
ALGOMA AND SUDBURY BRANCHES

The Chair: If I could then call on our next presenters, from the Algoma and Sudbury branches of the Victorian Order of Nurses. Welcome to the committee this morning. We appreciate you coming together and also presenting a joint brief. If you'd be good enough just to introduce yourselves. We do have a copy of your submission before us.

Ms Sharon Baiden: Good morning. On behalf of the Victorian Order of Nurses, Algoma branch and Sudbury branch, we are pleased to come before the Ontario Legislature's committee on social development. Bonjour. Nous allons lire cette présentation en anglais, mais si vous voulez, ce texte sera disponible en français.

My name is Sharon Baiden, executive director of the VON, Sudbury branch. With me this morning are Cheryl Sullivan, assistant executive director, VON Algoma, and Charlene Brown, the nurse manager with the VON Espanola suboffice. Together we wish to share with you a joint perspective from the area served by our branches.

1050

VON welcomes the opportunity to come before your committee today to comment on Bill 173, An Act respecting Long-Term Care. Our presentation will specifically respond to the approval and regulation of agencies for the delivery of a wide range of community services, the designation of approved agencies as multi-service agencies, the bill of rights for persons receiving community services, and the various statutes dealing with long-term care.

At the outset, we wish to commend the government for demonstrating ongoing commitment to involving stakeholders, volunteers, consumers, service providers and others across the province in health care reform. Again today you have shown your willingness to consult with the people through your visit to the Algoma district and your invitation to VON to come before you.

Ms Cheryl Sullivan: I'd just like to give you a bit of background. The Victorian Order of Nurses is a national charitable organization dedicated to providing health and related services to communities across Canada. As a major provider of nursing and other services in the home and community, VON believes that individuals have primary responsibility for their own health. The maintain-

ance of health directly and positively affects the quality of their lives.

VON believes that the value and the dignity of human life is respected. Individuals have the right to accept or refuse health care, to obtain information about their health and health care, and to participate with health professionals in making decisions about and plans for the provision of their care. Individuals and families are supported so as to enable them to live and to meet death in comfort and with dignity. VON believes that access to comprehensive, compassionate, family- and community-centred health care is the right of all individuals regardless of their ability to pay.

Health care providers collaborate to develop, implement and evaluate services which respond to the expressed needs of individuals, families and communities in keeping with the principles of primary health care. Volunteers make a valuable contribution by extending and complementing the services provided by health professionals. At the local and provincial and national levels, volunteers help to identify the needs, formulate policy, plan and promote, support and provide community health services. Community health services of assured quality are essential. VON has a responsibility to expand knowledge through ongoing research, program evaluation and education.

VON believes health is a resource for everyday living, an essential dimension to the quality of life. Health gives people the ability to make choices, to gain satisfaction from living and to manage and change their surroundings. As a non-profit registered charity, the VON works collaboratively to assess needs and to assist individuals in the planning and development of services to meet their needs. Charitable services are developed and delivered based on identified needs.

Fund-raising is an essential part of our charitable services. Fund-raised dollars are often used to develop demonstration pilot projects which prove the value of specific services. Such services may go on to become core services, part of the universal health system. Other charitable services will complement and enhance core services.

Ms Charlene Brown: Governed by a voluntary board of directors, VON is represented by a diverse cross-section of the community with a wide range of skills, expertise and commitment. The boards are fiscally accountable for branch activities and are responsible for overall directional planning.

Volunteers are essential to VON's ability to achieve our mission. Trained volunteers are critical to supporting professional providers and family members in an environment where high-quality, cost-effective services are necessary. Both VON Sudbury and VON Algoma offer services delivered by volunteers.

VON employs a range of professional, para-professional and support staff in the delivery of community-based services.

Over the years, VON has kept up to date with technological advances and has continually developed a diversified service base. We work to ensure a multidisciplinary

team approach to assess needs and to develop care plans in partnership with consumers. VON recognizes the need for consumer involvement in care and has encouraged mutual participation of family and other providers in the planning of care around identified needs.

Family and other care giver involvement is vital to all aspects of service provision. Through teaching and support, members of the team have developed skills to manage the elderly or chronically disabled. Our staff, volunteers and board members "care for life through respect, participation, responsiveness and courage." These are VON Canada core values. Practices are guided by the VON Canada mission, goals and objectives to ensure the maintenance of professional and administration standards.

VON Algoma and VON Sudbury cover a vast geographic area. Our branches have worked closely with the community to identify needs for services and to develop programs to meet these needs based on geographic and demographic considerations. Most recently, the Minister of Health appointed VON Algoma and VON Sudbury as joint sponsors for the establishment of a regional pain and symptom control community resource team. This program will serve all communities within the entire region.

Ms Baiden: Our primary service has been in-home visiting nursing, with an ever-expanding role as needs of consumers have changed and the focus to community-based health care has increased. VON has noted a shift in complexity of needs to include high-level assessment and specialty skills in such areas as palliative care, chronic debilitating illness, infusion therapy and pain management in both acute and long-term care conditions. The evolution of such services has provided an appropriate alternative to hospitalization and/or long-term care facility placement.

VON services are provided to all age groups, with the majority of consumers being the age of 65 and older. Maintenance of health and restoration to optimal levels of functioning through teaching, wellness promotion and supportive care are the aims of VON programs.

VON services are provided within a continuum of a quality management philosophy which incorporates a cost-effective approach to service provision. Within this framework, services are provided at the right time, in the right place and by the right provider. The approach is a consumer-focused process which centres around achieving outcomes that consumers feel meet their individual needs. Consumer choice is promoted, and participation in decision-making through involvement in care planning and goal setting forms the foundation of the service plan.

Ms Cheryl Sullivan: The programs presently offered by each branch include: in Algoma, visiting nursing, enterostomal therapy, shift nursing, palliative care specialty nursing, pain and symptom management, hospice volunteer visiting, placement coordination service, foot care, diabetic educator services and intravenous therapy; in Sudbury, visiting nursing, early postpartum discharge, palliative care, pain and symptom management, shift nursing, diabetic educator resource, foot care, adult day care, placement coordination service for Sudbury and Manitoulin, home support program in Espanola, insurance company assessments and hospice

volunteer visiting in Espanola.

Our future directions include new and expanded community-based programs to meet the challenges of promoting a healthier and more independent population. VON looks to the future as an integral partner in the reformed long-term care system to ensure consumer focus and participation, simplified access, an improved community-based service system, accountability to all areas, and planning through district health councils.

Since June 1990, VON has carefully considered the government's proposals for reform of the long-term care system. Through the changes in government and the ongoing review of the long-term care system, VON has been involved in discussion and response to the proposed changes, including a formal submission on Bill 101, An Act to amend certain Acts concerning Long-Term Care.

1100

Bill 173, purposes of the act: VON supports the purposes of the act. As an organization with a history of providing community-based, long-term care and support services for elderly persons, adults with physical disabilities and persons who require services at home, VON welcomes the creation of a new legislative framework for planning, managing and delivering community services. Over the years, VON services have expanded to provide a comprehensive range of services at home and in the community.

VON strongly endorses equitable access to community services through the consistent application of eligibility criteria. Flexibility in the model will be essential in ensuring the needs of each community are met. Innovation in service delivery is necessary to recognize unique consumer needs.

Efficient management of human, financial and other resources will be a critical success indicator. Resource utilization should be based on sound research and contain measurable outcomes, as determined by local communities in their development and evaluation of MSAs.

Given that communities will develop a model that best suits their needs, the potential exists for lack of standardization around services and programs throughout the province. We believe that it is crucial that in a flexible system of service delivery, a standardized approach to evaluation of the identified outcomes be developed to determine the effectiveness of any given model.

Measurement against a baseline criterion will allow for maintenance of local autonomy and the availability of core services on a province-wide basis, while ensuring key standards are met. Measurement and evaluation of services against standards and outcomes are an integral part of VON's business practice and are essential in quality management. Quality must be achieved in a cost-effective and efficient manner ensuring continuous improvement.

Ms Brown: Interpretation: The definitions as described in the act serve as useful clarification in a number of areas. Both consumer and provider involvement are essential in the development of the MSA. VON is founded on local community boards to achieve planning, monitoring, accountability and delivery of

services, in partnership with communities, clients, staff and other providers.

The bill of rights: VON recognizes and respects the rights of persons receiving community services, as described in the act. These elements are incorporated in VON's philosophy of service. An essential component of the bill of rights should be consumer choice surrounding service type, location or provider of services. At present, consumer choice is not clearly identified as being assured in the act.

Funding of services and approvals: VON supports the government's commitment to controlling health care expenditure. In managing resources, funds must be allocated according to strategic priorities, as determined by local communities. Caution is advised when considering the cost of the new system.

The MSA structure is a new concept with associated costs not known. Careful planning is necessary to ensure the goals of reform are achieved, while ensuring the rate of health care expenditure is controlled. Proven efficiencies must be noted in order to operate within limited resources. Where models do not demonstrate the ability to achieve the stated objectives of long-term care reform, a mechanism should be in place to mandate alternative service delivery models.

Providing services at home and in the community is a priority and is consistent with the government's strategic direction. VON notes, however, with concern that the legislation gives no guarantee of adequate funding for services to meet consumer needs. Consideration should also be given to assess consumer needs, demands and expectation and to balance service delivery on a funded or fee-for-service basis.

In consideration of MSAs, the number of standalone agencies needs clear analysis. In many areas of the north, small communities are looking for autonomy in the direction of their health and social services system. Some feel that separate MSAs for each community is the way to achieve this goal.

Movement in this direction could be the catalyst for the creation of a number of new agencies with layers of support and administrative functions that could significantly increase the cost of service provision. VON strongly urges consideration of satellite sites with a core of centralized support and administrative functions in conjunction with balanced representation at the board level in considering MSA services for areas with wide geographic dispersity.

Ms Baiden: I'd now like to speak to multiservice agencies as described in the act. Wherever possible, the existing strengths of agencies, services, and programs should be recognized and incorporated into MSA design. VON does not support dismantling the entire system, but rather suggests that weaknesses in the present methods of service delivery be identified and measures to improve such areas be developed. This will enable communities to move through the developmental phase of a multiservice agency with increased efficiency both from time and cost perspectives.

The VON proposes that an appropriate beginning to a

multiservice agency be the formation of a federation of long-term care health and social service community agencies committed to working together towards the stated objectives of long-term care reform. This coalition would include the establishment of an advisory committee that meets the recommended composition of the board of directors as described in the act and provides the connection between agencies and their respective boards of directors in an advisory capacity rather than in a governing role.

The composition of MSA boards as defined in the act demonstrate a broad range of criteria that would most appropriately ensure balanced representation. MSA boards should include providers of health and social service agencies who have expertise in direct service delivery and other members of the community to whom the MSA is accountable. Included in membership to the advisory committee in an ex officio capacity would be representation from the long-term care division and district health council to provide information and advice throughout the development to a fully integrated model.

During this transitional development phase, local boards would retain governance and accountability to consumers and the community. Such a model would ensure effectiveness in terms of cost, service, and quality through well-developed management information systems using common data standards province-wide, allowing for evaluation, monitoring and measurement on quality management indicators.

In evolving such a model, VON recommends the development of a system-wide record and documentation scheme. This would promote the sharing and exchange of information on a timely basis and with minimal repetition and disruption to the consumer. Simplified entry, a long-identified priority for consumers, should ensure access to services in a timely, unencumbered manner.

We believe this will be achieved through an integrated service delivery model featuring one-stop access to the core basket of services by telephone or in person, referral of clients to an appropriate service type, staff or volunteer provider, allowing consumer choice. Health and social service agencies have the expertise and experience in serving and meeting consumer needs. Consumers view much of health care coordination and delivery of services to be governmental and bureaucratic. Involvement of existing community agencies avoids the creation of another level of government sponsoring the MSA.

To ensure that consumers have a smooth transition through services, linkages with member agencies must be developed in the area of information systems. Rapid transfer of information and referral data is essential to timely access to services. Many agencies have fully integrated use of technology in their management of existing case loads. Again, present structure should be evaluated and built upon to avoid duplication and/or rework.

Volunteer involvement and participation in multiservice agencies is critical. Many have already indicated that they are not interested in volunteering for the government, hence further rationale to support a partnership model of community agencies where volunteer involvement is

extensive at present. Given the already stated value of volunteers and the need for fund-raised dollars, the legislation should clearly state the preference for a not-for-profit registered charity as the sponsoring agency.

During the transitional planning period, the partnership of agencies will work towards the mutual identification of a sponsoring agency meeting these criteria which will ultimately become the fully integrated MSA model.

1110

Ms Cheryl Sullivan: With regard to the rules governing the approved agencies, as stated in the act, the rules outline protection for consumers of services and ensure involvement by consumers in the development of their plan of service. Protection of consumers should also ensure that there are no waiting lists for core services from the MSA. With capped budgets and no alternative service available for consumers, MSAs may be prone to waiting lists. Placing consumers on waiting lists for core services could put consumers at risk and potentially increase their rate and frequency of admission to hospitals and/or long-term care facilities.

VON supports an assessment process that could be initiated by a client request for services, such as Meals on Wheels or home support. Further, with respect to eligibility determination, VON supports the need for an eligibility test.

VON is, however, very sensitive to consumers' common complaint that the present system is rife with unnecessary and/or duplication of assessment. The act would seem to continue this bureaucratic rigidity. VON proposes a less obtrusive system of self-reporting and eligibility, and self-application for services when this is possible. The development of a common assessment tool would assist in alleviating this problem.

In general, VON is concerned about the direction of the legislation regarding compulsory needs assessment by MSA staff for eligibility for all services. Assessment and service planning, as described in the act, should be utilized for more complex cases and clinical skills. Centralized telephone intake utilizing a risk screening tool could allow for separation of clients into those needs which require no further formal assessment or service plan. Others could be referred for more in-depth assessment. As previously proposed, electronic databases within the MSA on line with providers would aid in preventing duplication of information and assessment.

Rules governing service providers: VON fully supports the consumer's right of complete access to personal records, as indicated in the act. For approximately three years, VON records have been in the consumer's home. This has given consumers the right to document information on their record and to contribute to their own care plan. VON believes that the information in the record belongs to the consumer. Consumers further have the right to a copy of the record on request. The original belongs to the agency. In a multiservice agency, there should be one common record for the consumer with all providers of care having the responsibility of utilizing and contributing to a common record integrating consumer involvement and input.

With VON records being located in consumers' homes, we have recognized the need to protect individuals from accessing certain information and, thus, we support the process as outlined in the act for dealing with sensitive information.

Appeals: A process for appeals is a critical component to ensure that consumers have an avenue of recourse whenever there is a disagreement around the service being provided, denied or withdrawn. Again, this ensures consumers' rights regarding services. We strongly emphasize and support the need for timely appointment of dates for hearings.

Revocation and takeover powers: Revocation or suspension of approval of an agency is supported as another mechanism to ensure protection to consumers and compliance to standards.

Other issues and concerns: Given the diversity of Ontario in terms of geography and present service availability, the legislation needs to recognize unique challenges and dimensions to service delivery. The focus should be on ensuring core services are available and protected, avoiding bureaucratizing the MSA and allowing communities flexibility to design the MSA appropriate to meet their needs.

If the model for an MSA—multiservice agency—that evolves is one that includes the merger of existing agencies, VON urges the government to consider the needs for all employees in terms of fair and equitable opportunity for employment in the MSA. Such protection should be afforded to staff regardless of affiliation with unions. Employees represented by a bargaining agent have been afforded protection through the successor rights under the Labour Relations Act. Similar protection should be afforded to non-union workers affected by mergers in an MSA. VON recommends that the legislation be amended to contain a clear statement to this effect in order to provide for equal opportunity for all employees accessing jobs in the MSA.

In the event mergers result in severance of workers and other outstanding liabilities, such as with property, the government should provide funding to offset these costs. Presently, not-for-profit agencies, which deliver a vast majority of community-based services, do not have the resources to pay severance. In VON, surplus moneys have been returned to government or reinvested in the community to enhance service delivery.

The government has recognized that many charitable organizations are supported through donations and other sources of funding, such as United Way. In order to ensure the much-needed contributions to the charitable organizations, the MSA must be a charitable agency.

VON strongly believes in building on the existing skills and experience already in the community. Such a system is characterized by highly regarded health and community support agencies, volunteer commitment to and identification with these agencies, and the charitable, non-profit service offered in addition to government-funded services. The challenge is to achieve redirection goals building on the solid foundation of today.

In listening to consumers, communities, health and

social service providers and health planners, VON has concluded that there is strong support for the redirection goals of easier access to comprehensive and expanded services in the home and community.

Ms Baiden: I would now like to conclude our remarks. Our presentation today has attempted to highlight the changes needed for a sustaining system for community-based health and social services. As noted throughout our brief, the legislation addresses several areas for change in reforming the long-term care system.

To summarize, VON suggests the following areas be considered for revision in the act, as presently stated, including the following: Greater flexibility in the model for consumer access to services; development of provincial standards for delivery, monitoring and evaluation of core services; assurance of consumer choice; mandated alternative MSA models if objectives of long-term care reform are not achieved; guarantee of adequate funding to meet consumer needs.

We propose the consideration of transitional planning MSA model consisting of a coalition of existing health and social service agencies as an interim step in determining a final MSA model; a stated preference for a not-for-profit, registered charitable agency as the sponsor for a fully integrated MSA; mechanisms to ensure no waiting lists to core services; client-initiated assessment to allow for self-referral/self-reporting for services when possible and as appropriate; mandate to ensure the development of a common assessment tool and client record between agency service providers; protection of workers regardless of affiliation to bargaining units in the event of agency merger; in the event of agency mergers, stated protection in the act for severance and other liabilities.

VON is a respected, cohesive organization in which all members of board, staff and volunteers are committed to realizing the vision of health care for the province of Ontario. VON believes that the valuable skills, experience and innovation all community-based agencies, that for so many years have made significant contributions to communities, should be recognized, respected and further promoted.

Change must be well planned and integrate the strengths of the current system. The guiding principles of long-term care reform parallel VON's core values and fundamental philosophy. VON is committed to providing leadership through the transformation of our health and social service system.

1120

Mr Gary Malkowski (York East): Thank you very much for your very comprehensive presentation that raised both concerns and suggestions.

One of the comments that I have heard from a variety of organizations is the issue or concern that's been raised about volunteerism, as well as talking about a guarantee in terms of at least a minimum of service being provided, that there be standards. I'd like to hear your comments just in terms of volunteer issues. Do you see that the legislation should include some sort of coordination in terms of volunteers so that there is a way that we can make sure that the volunteer is recognized for the work

they've done, but also that we can somehow make sure they're maintained in the system? As well, how do you see both the coordination of volunteerism, as well as the issue of fund-raising?

The second point is just the issue of the guarantee of services. Do you feel that within the legislation those services that are listed do in fact guarantee a minimum of services across the province? Would you see any concerns in that? Maybe you could make some comments on that.

Ms Baiden: I'll respond to your first comments and questions around volunteers. I think you've mentioned some very key words, that being recognition.

One of the very significant areas that we find in VON is the very significant contribution that volunteers have made to a number of the services and programs that we offer from a governance standpoint as well from a direct service standpoint, and with that there has been significant need to recognize the valued contributions. What we're hearing from many of our volunteers is that by some of the proposals that are being suggested through the establishment of a multiservice agency, the very critical role and function of the volunteer is being lost.

From the point of view of fund-raising as well—you had a question about fund-raising—again, many of the volunteers are committed to the philosophy of VON by way of its charitable work and feel very committed to giving of their time to fund-raise and invest their time for dollars that are ultimately going to come back into their own communities.

You've also asked about the need to have a clear identification of the necessity to coordinate volunteers. VON has developed a number of programs whereby volunteer coordination has been a very integral part of the success of the volunteer work. Some of our VON branches have up to 100 volunteers, and so the point you raised around the need for coordination of volunteers is very valid and our hope is that the legislation would clearly recognize the work of the volunteer and as well have some stipulation that there would need to be resource to coordinate the work of volunteers.

I think the second question that you asked was around core services, and I'd need clarification on that question, if you don't mind.

Mr Malkowski: The legislation right now does reflect a guarantee of a minimum of services throughout the province, of core services, but you talked about, for example, making sure that waiting lists didn't come into existence because of the MSA being in place. Do you think, the way you read the legislation right now, that in fact a guarantee of services is entrenched in the act?

Ms Baiden: I think, in reading the legislation, it's not clear as to whether or not core services will be guaranteed in every community and the extent to which those services will be available. In some of the programs that we've seen kicked off in the community over the last few years, the services very quickly are identified as essential services, consumers seek to access those services, and it seems to be no time before they're full and we then see waiting lists.

I can speak, for example, to a home support program that we run in a small rural community, and it's a community that is budgeted, based on limited and capped hours. We do see the establishment of waiting lists and that's been necessary in order to manage to available resources, but we would like to see some type of assuredness that waiting lists for this kind of service would be alleviated, and not only through the assurance that the core service be there but the assurance that there's resource there to support the core services as well.

Mr Malkowski: Just on a point of clarification, Mr Chair, can I ask counsel to clarify the issue of minimum services being provided throughout the province. Could you just clarify that?

Ms Gail Czukar: The act requires that each MSA provide or ensure the provision of the mandatory basket of services, and that is the way the act guarantees there will be a minimum level of service in each community where there is an MSA, because they're required to provide those services.

In terms of standards and so on, there is the power to make regulations regarding standards of service delivery and so on, which I believe the presenters have addressed as well, and those will be put in place and there are currently program manuals circulating to that effect and so on.

Mr Malkowski: Thank you for sharing your feedback with us.

Mrs Barbara Sullivan: Thank you for a brief which really shows that you've gone from A to Z in this bill and considered the issues that your organization will face. I do want to point out, though, apropos of the last interchange, that in fact waiting lists are guaranteed. The services may be there but not in adequate numbers to ensure that they're provided in a timely fashion. What is guaranteed to the person is that they are put on a waiting list.

But I wanted to go to something that's really a core part of your brief. Your brief indicates, in fact, that the VON is supportive of a federated model and not of a monopolistic model. The federated model that you see would retain the spirit and the special mission, the expertise and a fairly extensive amount of the infrastructure of existing agencies; that would be integrated through a coordinating body. We could call it an MSA, but that would be the coordination. That model is precluded under this legislation. That model cannot take place under this legislation.

So what that leads us to is a number of labour adjustment issues including severances, including benefits interruption, including questions of wage parity, including pension plan changes, and the questions of worker protection which, in fact, you've raised in your brief.

The ministry committed the other day in our hearings that the government would pay for severances for people from your agency, by example, who were made redundant as a result of the new MSA. It seems to me that it's kind of foolish for the government to be putting money into paying severances to people who work in an existing agency, who are providing services which meet the needs

of the community. The government might have to take over capital assets or purchase capital assets from organizations like the VON and so on, instead of putting that funding into incremental services that are required to meet the needs of the community or into ensuring that the coordination of existing services, as you've recommended in the federated model, is in fact put into place.

I'd like to ask you two questions. First of all, do you think it makes sense for the government to be putting money into labour adjustment questions when service needs are still very much in existence? Secondly, do the people who now work for the VON in Algoma, in the Sault, in Sudbury, in Manitoulin really want to work for another organization that really is a government agency, no matter how you cut it?

Ms Baiden: I really appreciate some of the comments that you've made. One of the things that I'd like to clarify was in some of your initial comments around the MSA being a federated model. The proposal that we've suggested today is to establish a federation or a coalition of agencies very much as a transitional approach to developing a fully integrated MSA. In doing so, part of the hope would be planning around—in the event, the agencies that participate in that kind of model, through its evolution and streamlining some of the processes and getting a better handle on admissions etc, may find ultimately that is the way to go and that it works well. It's just that we have a system that needs a lot of improvement. Once those agencies start working together, it may become clear that it would be helpful to amalgamate some agencies or to ultimately have one sponsoring agency.

So to be clear, we're not proposing a federated model at the end, but rather a transitional kind of model.

Mrs Barbara Sullivan: But could I point out to you that you have no option for a federated model. Even if that meets the needs best in your community, there is no option under this legislation for a federated model ever to be put into place. You must go to the monopolistic model after four years of the transition period.

Ms Baiden: I guess then, just to respond to that, our hope is that there will be some flexibility on that whole question—I know right now the legislation is clearly precluding a federated model—by way of our proposal to have the legislation give consideration to this as a potential model. I think right now because we're talking about a model that hasn't been tested in terms of efficiency across the province, so that we would look to this to really be a means of bringing the key players to a common table to talk about and debate some of the problems and to ultimately improve the system by way of some of those key areas.

1130

Specifically, you've asked some questions around the government's commitment to funding liability, particularly around severance. In VON, some of the other liabilities that we have identified are things such as our occupancy where many of us are committed to long-term leases, but through the transitional planning period, there would be the opportunity to be planning for the transition of staff, if that's the way it goes, such that the liabilities in terms

of severance would be minimized in that staff would be transferred, but some of the very key concerns we have are around the liability that would be posed in the event of jobs being eliminated.

Mr Jackson: Sharon, how many employees are currently with VON Sudbury?

Ms Baiden: Just over 200.

Mr Jackson: And the work you do, have you any estimate of the amount of displacement that could be created if you don't win in a lottery of services from your MSA?

Ms Baiden: In terms of displacement, I would see that the services that we provide are essential—we're meeting a need—so under the MSA model, our view is that many of the services that are provided by our staff will continue to be provided by our staff, and we would certainly advocate that our existing staff continue to be the providers of service. Is that what you're getting at in terms of displacement?

Mr Jackson: Well, no. Virtually every group except for you have said there will be large displacement because of the 80-20 factor. If they consume all of your services, you might violate the 20% rule, so the chances of you surviving that lottery are between zero and nil. I'm just simply asking if you as an administrator have taken a step back and looked at what life might be like a year or two years from now in terms of not your workers but your agency. Those workers are going to be doing most of the work, there's no question about that, but I assume you're unionized? You're not unionized? What are you?

Ms Baiden: We're both.

Mr Jackson: You're both?

Ms Baiden: We have registered nurses represented by the Ontario Nurses' Association, and our registered practical nurses in the Sudbury branch are not represented by a bargaining agent, but in the Algoma branch our PNs are represented by the Practical Nurses' Federation, and in Espanola none of the nurses are represented by a bargaining agent.

Mr Jackson: So there could be a breakout at various ways depending upon the MSA's attitude towards hiring from a unionized base and a non-unionized base.

Virtually every group in the north is informed of huge displacements of staff. Some of them may get their jobs, but they won't be working for that agency, and I just wondered what position that puts your agency in.

Some are indicating that 90% of their activities are contained within this legislation; therefore they'll cease to exist. Some are saying a good 60% of their activities when—some of the Catholic service agencies that are tied to facilities, their adjustment is in a different framework, but VON is not associated with a given facility. A long-term care facility is a standalone, community-based support service, so you're 100% affected by this legislation would be my awareness of VONs in some of the presentations around the province.

Have you not given any thought to what would happen to your agency? Your parent association has pretty well concluded some things and shared it with this committee.

Ms Baiden: Thanks for the clarification. In terms of displacement, probably 95% of the services that VON is presently providing are services that would fall within that core basket of MSA services, so in terms of displacement, there would be the potential for our workers being displaced to another employer, that being the sponsoring agency, the MSA. I guess, as we have indicated during our presentation, we don't feel fully committed to the notion of dismantling the existing system and having agencies such as VON, Red Cross etc, collapse under the MSA and being absorbed or consumed by the MSA. So taking the extreme that that happens, the majority of our workers would be displaced.

Mr Jackson: Finally, there is a proposal before the minister which is receiving some favourable response with respect to an MSA in Wawa. Have any of you been familiar with or participated in development of that model, and to what extent has that—and I haven't seen that plan. We've requested a copy of it and we'll receive it soon, but until I see a copy, I need to rely on some feedback in terms of how VON participated in the development of that model and the comfort level of VON with respect to the ultimate model and how it's been presented in the shape and form in which it's now before the government.

Ms Cheryl Sullivan: In terms of the development of the model, we are aware that it has been developed. We have been allowed to sit on certain committees, mainly in a listening capacity. It's my understanding that there's a real possibility that the VON, as it is now known and working in Wawa, would not exist.

The Chair: We will have to move on. The parliamentary assistant had a last comment and then we'll go on to our last witness.

Mr Wessinger: I'd just like to thank you, first of all, for providing us with an excellent brief and also an individual perspective, which is something we don't get that often. It really is appreciated. Just to clarify a couple of points: First of all, with respect to the question of involving waiting lists, as you know, there'll be eligibility criteria provided for who gets the services and also criteria for prioritizing need. Hopefully management will minimize or eliminate waiting lists. The other thing, just a clarification to indicate that the MSAs of course, as you know, are not government agencies but non-profit. I think most of your recommendation are just excellent.

Mr Jackson: On a point of order, Mr Chairman: I understand the process for this committee is a process of Q and A and presentation of questions and answers. At the point the deputants indicated that they had not seen the Wawa model, to have this sort of spoon-fed pap about how wonderful this bill is going to be—

The Chair: Mr Jackson—

Mr Jackson: —in my view, Mr Chairman, that's not appropriate.

Mr O'Connor: Where's the point of order?

The Chair: Mr Jackson, that's not a point of order.

Mr Jackson: It's absolutely inappropriate.

The Chair: Mr Jackson, I'm sorry.

Mr Jackson: If you want to make this into a political

forum as to what this bill is or isn't going to do—

The Chair: Mr Jackson, you're out of order.

Mr Jackson: —it's simply a process to ask questions.

The Chair: No, Mr Jackson, that is not appropriate. Each member is free to ask a question or express his or her views on what has been said and each person will take what they wish from that.

May I thank the three of you for coming here before the committee and again for the brief that you presented. We appreciate it.

ALGOMA DISTRICT HEALTH COUNCIL

The Chair: I then call on our last witness for this morning, the representatives from the Algoma District Health Council. We welcome you to the committee this morning.

Mr Jim Dalglish: First of all, let me just introduce the people with me. Gil Contant is a provider member from Elliot Lake on the long-term care committee of the district health council. Valerie Scarfone is a provider member from Sault Ste Marie on the committee. Susan Van Atte is the health care planner for the committee. My name is Jim Dalglish and I am the chairman of the long-term care committee of the district health council.

Just to start off, we didn't come prepared today—we got asked this morning if we could speak and we're quite happy to do that, rather than speak to the legislation which we hadn't anticipated speaking to, although certainly we can comment, I guess, to questions and answers after our brief presentation to give you an update of what our committee has done to date throughout the region and possibly to end on the challenges that we see facing the committee, if that's agreeable.

I will turn it over to Susan, our long-term care planner, to give you an update of our activities today.

1140

Ms Susan Van Atte: The long-term care committee in the district of Algoma first met in February of this year. The committee has 24 members, a cross-section of consumers, providers and others from across the district, also representing a number of cultural and ethnic groups on that committee.

Some of the activities: As you know, there is a lot of information surrounding long-term care and one of the biggest tasks that we had to do was educate the committee and also the public in terms of what the policies and guidelines were.

One of our first activities concerned supportive housing consultations, and in conjunction with the long-term care division, which I should add has supported us in the planning process, we held a number of meetings in Hornepayne, White River, Wawa, Sault Ste Marie and Thessalon around that particular policy paper. We also used those meetings as an opportunity to provide education on long-term care in general.

We struck a number of subcommittees to assist the long-term care committee, and one of those was a supportive housing committee, which has sent out a call for proposals with a deadline of the end of September for new moneys that came our way in Algoma.

We recognized very early in the process that we are such a large district, and it was very difficult to conduct a planning process with one long-term care committee. We felt we needed to have advisory committees from different localities across Algoma and so we have long-term care advisory committees in central Algoma, Hornepayne and east Algoma.

We have struck a multi-year-plan subcommittee which has just begun to meet and is challenged with bringing together all of the information that we need to make informed decisions around the needs and priorities in Algoma.

We recognized early on in the process that communication was key to the success of the planning process in Algoma, and we have a communications subcommittee. We publish a monthly newsletter, and that is what we've circulated to you this morning. The newsletter appears monthly following our long-term care committee meetings, and it's distributed to key agencies and to individuals across the district to bring them up to date as to what we're doing. It's also published in French and in large print for those individuals who are visually impaired.

The committees: perhaps the majority of their activity has been around the multiservice agency development. We set out in early May and June to hold community meetings to inform residents of the communities across Algoma what the multiservice agency development was all about. We asked for their input as to what they felt would be the successful outcomes for an MSA, and also we began to have some dialogue around possible options for our district.

The meetings we held were in Hornepayne, Sault Ste Marie, central Algoma, Blind River and Elliot Lake. People were nominated from those meetings, along with key providers, volunteers and consumers, to come to what we called a pre-design multiservice agency workshop in the middle of June, and at that point we identified in more detail some of the successful outcomes that we needed for Algoma.

We also asked for input at those meetings regarding our planning process, and suggested a process that we would follow and asked for input and whether or not people agreed with the process that we had laid out, and we have since amended that based on the input that we received.

Regarding the multiservice agency, we sent out a call for ideas with a deadline of September 30 for more specific input around models, and we're awaiting responses, and those responses, in addition to meeting with providers and the meetings that we already have, will form the basis of a discussion paper which will go out for community consultation and have specific recommendations from the district health council.

There have been dollars made available for transitional stages in the multiservice agency development, and to date, we know that there appears to be interest from some of the providers in Sault Ste Marie and the providers in east Algoma to apply for some of these transitional dollars.

Now I'll turn it over to Jim, who is going to highlight some of the challenges faced by the Algoma District Health Council.

Mr Dalglish: The challenges that we foresee obviously include the geography of the Algoma district. It's quite large. The distance from the main population base of Sault Ste Marie is significant for meetings and for people to get in. Many of the individuals living in the district live in remote rural areas, which causes some issues on delivery of services and so forth. There's a lack of professionals in the remote areas. Many of them are based in Sault Ste Marie, which, once again, causes issues to get those services delivered close to home, and to attract professionals and retain them is another ongoing issue for this area.

Hornepayne, which is part of our district, is almost seven hours away from the Sault and receives services from Algoma, Cochrane and Thunder Bay, depending on the services being provided, and that has some unique challenges as well, to plan for that.

We are struggling right now with the providers wanting to move ahead with the transitional stages of MSA. We're very happy to see that they are moving forward in different regions in the district, working with other local providers in that area to put some ideas forward, but at this point the long-term care committee has not decided how many MSAs there shall be for community consultation, and therefore it's sort of difficult to provide advice and comment, as the local providers meet and get input from their local consumers.

That will be an issue we'll be grappling with, I think, in the next two to three months, as proposals start surfacing and as we, as a long-term care committee, start grappling with the economics of one MSA, two MSAs or three, recognizing at least the assumption that I think some of us make: The more MSAs there are, presumably the more administrative costs that will be incurred. That's an assumption at the present time. I think it's fairly valid, but time will tell. We're grappling with how to capture those costs as we're projecting our views on the administrative costs versus the individuals who might be managing or running those organizations in the future.

As I've heard just recently, there is the challenge of human resource changes, which is also very difficult for the providers to deal with and for all of us to deal with, the difficulties of keeping the communication channels open and dealing with people in other communities. The providers in the outlying areas, from Sault Ste Marie—and they're not small, by any means—feel that they have as much voice as some of the major providers in Sault Ste Marie. That's an ongoing issue for any service being provided in this region. We have a concentration of population in the Sault and also Elliot Lake, and somewhat in Blind River, but not as much, and we have to take that into account as well.

Our major task is a fairly heavy workload, we think, that is being asked of district health councils. It's certainly challenging. It's a real challenge for the volunteers who are receiving services or have family members receiving them, to educate and keep them informed and for us to get their valuable input, but it's a lot of reading

for them and a lot of knowledge to obtain in a very short time, to ensure that their participation is valuable and worthwhile. We've had some comments from some of our consumers, as we sometimes slip into jargon, using health terms and so forth and then try and bring ourselves back to that.

Then, of course, the issue: Can we meet the time lines imposed by the Ministry of Health? That's always an ongoing issue for us.

Mr Chairman, those are the challenges that we see at the present time and we on the panel would be quite happy to try and answer any questions.

1150

Ms Barbara Sullivan: Thank you for the summary of the activities of the DHC with respect to reform of long-term care. I'm also particularly pleased that you've outlined the barriers or the difficulties in coming together with a plan. I think your underlining the effects of remote areas, of the geography and distance, of the economic issues and of the human resources issues are extremely important for us to understand this entire scenario.

I'm interested in the time lines you've talked about, particularly with respect to the MSA task force that you've undertaken. I understand from your scenario that you will be looking for a discussion paper for circulation some time late in the fall after the September 30 call for ideas. Subsequent to that, how long do you think it will take for the Algoma DHC to come forward with a recommendation with respect to MSAs and the appropriate mechanism, and then how long after that are you projecting that the MSAs would be up and running?

The reason I ask this question is that it's very clear that the government's intention is to go to the Legislature for third reading of Bill 173 this autumn, and the model you came up with, the model the community prefers, may in fact be precluded by the legislation that goes ahead.

Ms Van Atte: We originally felt that we would have some decisions, firm recommendations, possibly by the late spring, around the specific models that we could then submit to the Ministry of Health for approval. We really didn't anticipate that we would have a board in place until probably the end of 1995.

Mrs Barbara Sullivan: You have talked about the distance between your communities and the small areas which have to be incorporated into your design. If it's the view that a federated model, by example, of service delivery is in fact the most amenable to your community, what choice will you have then at the DHC latterly?

Mr Dalglish: Maybe I could comment on that and then maybe if someone else wants to comment. I think what's likely to happen, from my talking to different people and understanding of where I think some communities may be coming from, there's likely to be a request from the providers and possibly the communities for more than one MSA in the Algoma district.

One of the things we're looking at doing is trying to speculate, and that's all it is, on what the administrative costs are for one MSA versus more than one, and that seems to be one of the thrusts of the proposed legislation right now, to try and redirect money from administrative

costs to direct service provision. I think it's likely to be that we'll have a debate on our long-term care committee as to how many there shall be. I'm hoping to focus the dialogue in that regard and come up with possibly some creative model that will meet the needs of everybody, but keeping the long-term administrative costs to what is intended; I guess to a lower minimum dollar amount than what is currently being spent.

Mrs Barbara Sullivan: In my own community we have a lot of pressure for more than one MSA and a second MSA would be located, by example, 20 minutes from the physical location of the first. You're dealing with quite, quite different scenarios. Hornepayne, I understand, has just contracted with the new primary care doctor for the next two years, seven hours away. How are you going to deal with that situation without incremental costs if there is more than one MSA?

Mr Dalglish: That's something we'll have to explore, obviously. I think there will be a push for more than one MSA and we'll have to see if that makes sense or not and come to a consensus as part of our process. I think the other issue that you've raised is the fact—I have a sense, from the major providers anyway, in this community, there's a growing consensus to go to the federated model I think, which you indicated previously and which I'm aware of, that the legislation doesn't allow. We're certainly going to have some dialogue over that. I think it was wise to have access to transitional models. I guess where the real push comes is, at what point do you get out of a transitional phase, which right now is a maximum of four years, and get down to one larger agency?

At the present time, from my perspective as chair of the long-term care committee, we would be looking for some kind of commitment on proposals to tell us how that is going to take place, before approving requests for transitional models. I've had dialogue with some of the major providers in the community already in that regard. I think without that, you don't get some of the gains, as anticipated in the legislation right now, personally.

Mr Jim Wilson: Thank you, members of the district health council, for your presentation, it was most informative. I also appreciate the updates in terms of the newsletters that you've provided us with. I note in the first one that's provided, chronologically anyway, April 1994, there's a comment about how MSAs will be governed and it says that, "MSAs will be non-profit, incorporated agencies, operating at arm's length from the provincial government."

I'm just wondering if, after you've now seen and studied Bill 173, you still feel that MSAs are truly operating at arm's length, given that MSAs exist strictly at the pleasure of the Minister of Health and the government of the day. Their bylaws need approval, the makeup of the board's prescribed, services that are to be delivered need ministerial approval, the fees are prescribed too and how they can be collected. There's an 80-20 rule imposed. Eligibility criteria will be prescribed by the government, various notices that have to be provided to consumers are prescribed, recordkeeping and reporting are prescribed. In addition, there are 42 other regulatory

powers. Now that you've seen the bill and studied it, do you still think these things are operating at arm's length, because this is the most bizarre arm's-length relationship I've ever seen?

Mr Dalglish: I guess I'll comment. I wouldn't disagree with the thrust of your comments, but I would frankly see that some other sectors of the health care industry, such as other aspects of long-term care, I don't think are that much different at the present time than MSA development. I think there are a lot of rules and regulations in health, in a lot of cases for very good reasons, I guess. If you're working in the environment you certainly may feel at times there are overprescriptive rules and regulations, but I don't see that much significantly different, as far as the control mechanisms for MSAs, as some other aspects of some other health services being provided. I'm just speaking personally now.

Mr Jim Wilson: Except that when we started in to long-term care reform and the consultations over the last couple of years, the sales job by the government I think left the impression that these would be far more arm's length, more autonomous and greater flexibility in local communities. Most of the presenters to date have indicated that there's not a great deal of flexibility.

1200

Mr Dalglish: As I just reiterate, I don't think there's much flexibility in some other sectors of the long-term care either, from what I see.

Mr Martin: I want, as well as the others, to thank you for coming today and thank you for all of the work you've obviously done up to this point. I know it's a tremendous amount of time and energy and when, as you have stated, you consider the distance you folks travel to get to meetings and things like that, it certainly is impressive. And all of it, for the most part, volunteer. That's an interesting piece of this whole puzzle as well and I'll get to that in a minute.

I also want to thank you, Jim, for your letter suggesting that this committee come into the north. I don't specifically say Sault Ste Marie but I thought, since you invited, we try and get the group here. It's good that you came and we can hear from you, so thanks for that.

I wanted to follow up a bit on Jim's line of questioning, because I think it's important that this whole question of local planning, local control, local autonomy—certainly Sault Ste Marie is not known to be a community that kind of rolls over and plays dead. I think over the years we've proven that we have a mind of our own and we're willing to stand up for what we believe in.

Certainly the group you've put together here that's in this pamphlet representing the area—I recognize most of the people here and they are very highly motivated, self-driven and are going to make sure that we get something here that's going to be helpful to the region.

I wanted to ask you, re the legislation, we've been criticized as we've gone around the province for being too prescriptive; we've been criticized for not being prescriptive enough. Maybe that's good in that we hope to land somewhere probably in the middle, because I

think it's important that we put a framework in place that will be helpful, as opposed to full of holes. I'd like you to comment on that.

With your experience so far of this process, do you think you're being allowed to make decisions that will in fact give us the best possible return for our investment in this area? The question of volunteers: Obviously, so far, this whole operation has been driven primarily by volunteers, the district health council is volunteer, your group is volunteer, and you talked initially about consumer volunteers on the group.

Do you think you'll be able to maintain that momentum once we get into the real, nitty-gritty MSA and down the line a ways?

Mr Dalglish: I think the volunteers certainly—and we have some concerns about them as well. Keep in mind our volunteers tend to be—some of them anyway—not the healthiest individuals, and we've already had discussions after sitting for—we typically have three-hour meetings, although we've had the one-day, all-day session. The one-day session was certainly a burden for some of them to stay tuned and so forth, so we have to be a little careful in that regard and we're trying to keep that in mind.

I think the volunteers can only go so far. We certainly want their input. As they receive services, they can tell us where the problems are and so forth and we can try and address that. I think some of the principles or major principles that the legislation is aimed at does this. I would indicate from my knowledge—because I was on a long-term care committee, the old one, probably seven or eight years ago—some of those principles, like one-stop shopping, have not been changed that much from back then under different parties in charge type of thing.

I think there's a clear consensus that some of those principles are very desirable to work towards. I think it's very difficult for the providers—although I think the transitional process has given us some impetus to get together. My perception of providers locally and across the district along with the consumers is that we already have good relationships in place, people work closely together. I think this is quite frankly forcing people to work that much closer together, to contemplate such things as one chart, one assessment and so forth.

I think, all in all, it's certainly difficult to argue against the goals that are intended, but we've already had some consumers drop off our committee and subcommittees just because of the time commitment and their ability to travel because, as Susan has indicated, we have—at least, Susan has and some others—across the district and that's quite challenging for people to make the time. As a matter of fact, in the audience today, there's a good representation of the members of the long-term care committee. There must be at least half here in the audience, which I think once again indicates very good interest in your proceedings and in moving forward with the legislation.

Mr Martin: I just want to focus for a minute on this question of the interim and then the long-term MSA and the federated model that was proposed. You were here—maybe you weren't—when the hospitals came in and

presented that they had found—any of us who live in this community know that over the last 10 or 15 years there's been a big question about how we can amalgamate the hospitals. I think there were some who were convinced that it could never happen, but it did. A model was put together that seemed to fit the needs and the concerns of the people involved.

Is there any way in your mind, given the creativity and energy and intelligence that's on your committee, that we'll be able to find some way of incorporating, if not a federated model, at least something that will capture the essence of what's there already? This legislation is about building on what's already out there that's good. Is there any room there that you can see that would allow for some more creative model that might fit?

Mr Dalglish: I think the federated model, frankly, only gets you part of the way there, and having worked in one of the local hospitals for quite some time and having been through a number of the rationalization discussions, merging, amalgamation and so forth, I sort of think I have some insight into the pros and cons.

One of the things we've openly discussed, that I have raised with at least one or two providers, is right now I think the legislation covers unionized workers; they're basically protected. I think the VON, as I've read their brief previously, makes a very valid point: Why aren't the non-union people provided for as well? I think one of the sticking points, frankly, on moving from the federated model to a new entity, I would suspect, is the concern, and I think rightfully so, of the loss of jobs and careers of different individuals. I've raised it with a couple of people. What if locally we decided that we would guarantee there would not be loss of jobs, but we would do it over a period of time? This creates its own problems, quite frankly, in doing that, but that's one of the great fears. Of course, another fear is that different organizations that have long histories lose those ties as well.

Similar to the hospitals, at some point if you're going to move forward, you have to bite the bullet, so to say, and make some decisions.

The Chair: Thank you very much. I'm sorry, we're out of time, but on behalf of the committee I want to thank you for coming. It's been very useful, I think, to hear what you have been doing as a planning group and, as was mentioned before, we thank you for the newsletters that you have left with us.

In adjourning, if I could just remind committee members that we start again at 1:30. I also need to advise you that you must check out of your rooms here before we come back. So if you could just remember to do that, they'll look after the bags.

The committee recessed from 1209 to 1333.

PORCUPINE HEALTH UNIT

The Chair: Good afternoon, ladies and gentlemen. I'll call the meeting of the standing committee on social development back into session. We continue our hearings in Sault Ste Marie. Our first witnesses for this afternoon are representing the Porcupine board of health and the Porcupine home care program, if I could invite them to

come forward and begin their presentation. As you come forward, we're just getting a copy of your submission passed around, if you'd also be good enough to introduce yourselves for Hansard and members of the committee. Welcome.

Dr John MacIntyre: Thank you very much, Mr Chairman. My name's John MacIntyre. I'm the acting medical officer of health for the Porcupine Health Unit.

Ms Joan Cameron: I'm Joan Cameron. I'm the director of the home care program for the Porcupine health care unit.

Dr MacIntyre: Mr Chairman, we thank your committee for giving us an opportunity to meet with you today. The text of our presentation is in front of you and I'll essentially be following what we've prepared for you in writing.

We are here today representing the Porcupine Health Unit as a community-based provider organization, but we also wish to speak for the organization as a member of the community in the district of Cochrane. The health unit has been in existence for 50 years, with 24 years' experience in the development and delivery of in-home services.

The Porcupine home care program serves a population of approximately 94,000, with a central office based in Timmins and a network of eight suboffices located in major community centres across the district.

Our home care program includes placement coordination services as well as the delivery of acute care, chronic care, integrated homemaking and school health programs. Crucial to the quality and comprehensiveness of service provision in Cochrane district has been the close working partnership established among related health and social service agencies. We now maintain service contract agreements with 20 independent agencies and coordinate activities through functional relationships with several other volunteer groups and provider organizations in the community.

Notwithstanding the record of achievements to date, substantive reform in the delivery of community-based care is essential if our society is to be prepared for the future. Economic and social realities demand it. The question is not whether change is required, but what changes are necessary and what would be the best and most opportune way to proceed.

There is a risk, however, that in undue haste to change the system we overlook or even discard lessons from what has already been accomplished. In-home services in the Cochrane district have grown from inception in 1968 to a broadly based and highly adaptable service structure operating on an annual budget of \$7.4 million. On a provincial scale, health units have overseen the critical early stages of program introduction and later years of expansion and innovation in 32 of 39 home care programs which now operate in the province.

All this was accomplished under a simple legislative mandate, "Every board of health shall superintend, provide or ensure the provision of...home care services that are insured services under the Health Insurance Act, including services to the acutely ill and the chronically

ill." That's one sentence, and our working copy of Bill 173 runs to 53 pages.

If Bill 173 is indeed the answer, then we ask, what is the question and where is the evidence that such extensive and complex legislation is required to further the purposes of long-term care reform? We believe that much more can be gained without such an excessive degree of legislative intrusion.

It is almost as if the authors of Bill 173 are intent on re-creating the system from bottom up. Would it not instead be reasonable first to evaluate current standards in community service delivery and use this as a point of reference for choosing preferred strategies of improvement? If health units that currently manage home care programs are not to be that benchmark, then what standard of performance will replace them?

Section 11(3) of the proposed act relegates our health unit, along with all others in the province, to least-favoured status as an agency of last resort. We have been left only to guess at the reasons for this bias. Does the evidence available repudiate so completely the results in home care achieved under the direction of boards of health? It seems almost embarrassingly obvious that all across Ontario where home care programs exist, either alone or in conjunction with public health programs, multiservice integration of long-term care is already quite advanced.

In the press, in position papers and in public statements, generalizations abound. There's been a regular stream of criticism against poor quality of service, lack of coordination, barriers to access, inequity and administrative waste. The massive rollout of long-term care redirection has induced a wave of discontent, fear, anxiety and unreasonably high consumer expectations. A consulting group reports that administrative costs for certain programs around the province range up to 40% of total budget, and a cloud of suspicion hangs over all of us. There remains a pervasive sense of management incompetence, waste, duplication and provider ineptness on a scale that warrants radical and rapid restructuring of long-term care delivery.

If this truly represents the benchmark of performance, we agree that sweeping legislation is urgently needed. If otherwise, however, we would urge more patience and a more deliberate approach in evaluating and implementing options for long-term care reform at the local level.

The proposed act, quite correctly, builds on several goals and principles which are central to reform. Part I specifies that the main purposes for the legislation are to ensure that community services are available as a substitute for institutional care, to improve quality of community services, to respect individual autonomy, to simplify and improve access, to promote efficiency and equity, and to encourage community involvement.

1340

The fundamental purpose of this act, of course, is not simply to declare the virtue of reform principles and goals. Rather, the act interprets reform principles by setting out a particular form, or the parameters to define the form, in which they are to be applied. Our community

has barely begun to address the implications of different models of delivery for long-term care. It is premature, therefore, for the government to present draft legislation and expect to receive well-informed advice. We agree and re-emphasize that community involvement is the only guarantee of successful reform, but informed community involvement is just as crucial, if not more so, during the formative stages of health reform law as it will be after new legislation comes into effect.

To this point in time, our community has no framework for the evaluation of service outcomes as a test of different multiservice integration models, we have no standard measure of relative costs or method for understanding the relative advantages of various administrative structures, nor have we evolved a basic agreement among ourselves on the role and mechanism for ongoing community consultation, yet Bill 173 deals with all these issues and would lay the foundation for many years to come. We are told by the Ministry of Health, however, that the MSA concept will work, but is this assurance good enough in itself? Is it not at the very heart of community involvement that we as a community must believe it will work?

Before local communities can properly advise the province on a suitable legislative framework, one that will sustain the goals of reform well into the future, there are three aspects in particular of Bill 173 which require more time for discussion at the district level: One concerns the scope and practical effect of multiservice agency autonomy relative to the degree of central ministry control; a second pertains to the accountability of approved agencies for equitable resource allocation on behalf of the whole community, which has to be balanced against obligations to individual consumers; and the third concerns the concept of continuity of care in community-based services. Unfortunately, to date our community has not had the opportunity to hold thorough or well-considered debate in these areas.

Regarding local agency autonomy, it is instructive to compare Bill 173 with the mandate that has been vested in boards of health under the Health Protection and Promotion Act. Boards of health retain a wide margin of discretion in the design and delivery of mandatory health programs and services. Service standards from the ministry are issued in the form of guidelines, allowing choices to be made which adapt to local priorities, social characteristics and resource capacity. Relatively speaking, the concept of administrative control and accountability proposed in Bill 173 creates an immeasurable and worrisome potential for management by regulation.

We believe that local communities, through the agency of district health councils, must be engaged more fully on the issues of distribution of authority before a law is struck. Needless to say, whatever principles of governance are written into long-term care legislation, these will establish a precedent for accountability relationships in all other sectors of community-based care, including public health.

With the exercise of local autonomy there emerges a fundamental economic conflict between private and public welfare. Directly associated with this dilemma is

the problem of defining a list of mandatory insured services. Obligations to the individual consumer cannot be open-ended. The law must constrain individual rights to maintain costs within affordable limits and ensure equity of access for the community as a whole. Granting legal sanction for waiting lists, as is done in Bill 173, is not the answer.

The complexities entailed in achieving equity of service, access and affordable coverage cannot be micro-managed through central regulation. Our community, however, is not yet ready to assume such responsibilities, nor are we sufficiently well informed to make recommendations on an appropriate devolution of powers to local approved agencies.

Moving slower with the passage of long-term care legislation will not mean that needed improvements in the system will suffer unacceptable delay. One needs merely to consider the intensity at which progress is now being maintained. For instance:

—The Ontario Home Care Programs Association and the in-home services branch of the Ministry of Health are presently revising regulations, policy and procedure to provide more flexibility in the mix of services and extended hours for service, which together will result in better use of resources.

—A patient management information system and ACCPAC accounting system have been installed across the province, promoting greater utilization and fiscal accountability.

—Consumer representation has been expanded on various municipal planning committees, advisory boards and management boards.

—The Porcupine public health and home care programs are collaborating in the development of a health information centre and referral service that will be run by senior citizen volunteers.

—The long-term care planning committee for Kapuskasing and neighbouring communities has submitted a proposal for a 1-800 service to be operated by the Porcupine public health and home care office.

If the province truly believes that local communities have both the resolve and the ability to make wise decisions, then the results demonstrated thus far should persuade us that reform does not require immediate legislation. The essential conditions for change at the present time require a clearer mandate from the provincial government in support of the district health council role as a leader in local planning and negotiation.

Bill 173 introduces an amendment to the Ministry of Health Act which is supplementary in nature to the provisions for long-term care delivery. In fact, the relative importance should be reversed. Workable answers to the tough questions of social program delivery will be found where local communities hold themselves accountable for honest debate and dialogue. A reinforced mandate for DHCs should state that health councils have a primary accountability to the interests of their own community and that their role as advisers to the minister should be to advocate for the local perspective. Stable and steady progress in health system reform requires this

expression of confidence in the local capacity for self-directed change.

In conclusion, we offer the following recommendations.

First, based upon the considerations previously presented, we maintain that Bill 173 is premature. It is therefore recommended that third reading of Bill 173 be delayed until specific regulations, program guidelines, policies, procedures and user-fee structure have been drafted and presented for consultation at the district level.

Second, given that the principle of community involvement depends upon having legitimate responsibility and a commensurate level of local authority in planning, development and implementation of health reform, it is recommended that the Ministry of Health Act be amended to mandate district health councils as planning and negotiating authorities within their geographic jurisdictions; to empower DHCs with fiscal responsibility to plan, develop and implement programs such as MSAs; and to provide adequate means with which DHCs may fulfil this expanded mandate.

Third, grounded in the knowledge that progress in long-term care must and can continue unabated without waiting on new legislation, it is recommended that service providers in each community place a priority on simplifying access to services by providing a one-stop information and referral system as soon as possible and that government commit the necessary funds to put this strategy into place.

Fourth, given the prevalence of misinformation, misunderstanding and confusion which now surrounds the purpose and promise of multiservice agencies, it is recommended that prior to establishing a provincial mandate for MSAs, a measured approach be taken for the development of pilot projects which can be properly evaluated.

Fifth, and we call this our recommendation of last resort, in the absence of reasonable justification to the contrary, we recommend that section 11(3) be deleted.

1350

Mr Jim Wilson: Thank you for a submission that's full of common sense. I'm coming to the same conclusion that you're submitting today, and that is that the government really should take a break from these hearings and come back with a redrafted bill, because a number of the concerns we've heard throughout the province would require substantial redrafting and, in fact, reintroduction of a new piece of legislation.

I appreciate your comments with respect to asking the government at this time to take a step back from this process and allow local planning and local initiative to continue, because it really has started in a number of areas in the province, in most of the province. There are some areas, like my own in Simcoe county, where it's a bit of a dog's breakfast and I'm not sure how the government's going to get all the parties together. I think that mainly comes from morale being pretty bad there, and people don't like having a gun to their heads when asked to come together and cooperate on a so-called volunteer basis among agencies.

You call recommendation number 5 your recommendation of last resort. I think it's a good recommendation because I'm not sure why the government has a bias against boards of health, or municipalities in this case, other than they've made utterings that the construction of boards of health is not leaving room right now for consumers and that sort of thing. We do tend to forget, I think, that a number of people who are on boards of health are human beings and they're also consumers.

But would it be your contention there—because I think the government sees this legislation as a cornerstone in their health care policy and I'm Health critic for my party and I've been hearing about it for a long time. They're going to move ahead with some form of legislation. I suspect it'll be substantially what you see before you now. Perhaps we could help you with an amendment by deleting 11(3)—that's your suggestion—or, if the government wouldn't agree on that, should we not just try another approach and say that perhaps boards of health, before they can be designated are opened up to greater consumer participation? Help me out here because the government doesn't very often accept amendments, in the four years I've been Health critic anyway.

Dr MacIntyre: The concern about boards of health and their representativeness, the nature of their governance model, is certainly a concern that I have, but not solely in relation to long-term care. I think there may be an inherent contradiction here, if I may call it that, in that public health is very much a community-based service. If it's deemed, for whatever reason, that the governing structure that's now represented by the board of health model is inappropriate to community-based long-term care services, then does that not automatically make it invalid as a sufficient governance model for public health?

Mr Jim Wilson: Don't tempt the government.

Dr MacIntyre: Okay, let me take this one step further.

Mr Jim Wilson: They're getting rid of a lot of other agencies, so don't give them any good reasons.

Dr MacIntyre: I don't know whether it's a matter of getting rid of it. I don't fear that public health is somehow going to slip beneath the surface of the water and disappear for ever. Yet I think it's only fair that community-based services be considered as a unit. This is, again, an extension of this governance model, a distinction that's being made between a governance model for long-term care and what perhaps might be approved for public health. Is that not inherently a fragmentation of community-based care?

In all my practice, we are finding intersection. Certainly in the Porcupine Health Unit we have intersection between those. I mean, public health is very active in immunization. Every fall we launch a major campaign on behalf of the elderly in our community to make sure that they're all adequately protected against influenza. Is that not a critical component of clinical care, to maintain the independence of individuals at home?

I agree, I would not argue against the change, but there are two things here. Let's be consistent about the nature

of the governance model that's appropriate across community-based care. Second, let's not make artificial distinctions between long-term care as a community-based service and public health as some separate community-based service.

Mr Malkowski: Thank you for your presentation. I was listening to your recommendations and I think all of them deserve consideration, but talking about number 2, saying where the district health councils become more financially accountable, and number 4, talking about pilot projects, I'd like to ask a question. When you think DHCs are ready to make recommendations, in terms of having an agency, perhaps there is a district health council that has worked with the agencies and is ready to go ahead with the establishment of their MSA. Do you think that they should have the opportunity to do that? We allow them to go ahead and yet we still go ahead with the consultations and with the legislation, so that would be a kind of pilot project.

Dr MacIntyre: If that means concurrent movement on, say, two tracks, if I understand the question correctly—

Mr Malkowski: Yes, that's right.

Dr MacIntyre: —I would think that from the standpoint of maintaining purposeful community involvement, one track should be ahead of the other track. What I'm trying to state here is that the sequence is important. I'm not speaking from a provincial standpoint but from our own experience in the community. I really believe that this legislation is well ahead of us, well ahead of our ability to comprehend the implications to our future development. Quite apart from the DHC role, whether it's going to be more fiscally responsible or otherwise, I do believe that as a community under the guidance of the DHC, we do need a good bit of time just to digest what's already before us. If it's all right, Joan might have something to add to that.

Ms Cameron: I believe at the present time, and I speak for the northern district of Cochrane, its services are well established, based upon an infrastructure that has grown over a 24-year period. Much of our service delivery restriction is based upon our inability to recruit and retain professionals in the north. This continues to be a constant problem, but we do try to provide equitable access for all who require care to the resources we have.

The infrastructure is based upon a series of suboffices that report through to the Timmins central office, but each office is autonomous in its own ability to interact with the formally contracted service providers within that community, as well as functionally with other service providers. We've indicated in our presentation today that we do have 20 formal contracts with other service providers. Representatives of these agencies meet frequently in case conferences, in supervisory meetings and over the phone at night, because most of our area is already on call, providing service 24 hours a day, seven days a week. We've leapt ahead of the legislation, so to speak, responding to the needs of the district in the north and the various communities.

We try to provide care that is sensitive culturally, religiously and linguistically as well as care that meets

the individual, minority and personal differences of people. We try to match care givers with these needs.

Most recently, we have become involved in launching a new area of service. I'll be opening up an office with full service on Moose Factory Island in the middle of September and yesterday received an invitation from the chiefs on the James Bay coast to meet with them in Attawapiskat, Kashechewan and Fort Albany in the middle of October.

I only emphasize the success of the program based with the Porcupine public health program to date because I do think we have provided a very good level of care and the majority of our clients and families indeed speak very positively of the services that we provide.

Mr Malkowski: Just a point, if I could ask the parliamentary assistant: The DHCs, if they make a recommendation for ministry approval, would they continue on then, even though the legislation is still in process? How would that work?

Mr Wessenger: I'll make a preliminary answer and then I'll let ministry staff follow up, but it appears to me that to establish an MSA, you actually have to have the legislative framework in effect before one can be established. You can certainly plan for one ahead of time, and that's what we're trying to do. I'll just ask if Mr Quirt can add anything further to that.

Mr Quirt: Clearly, you would have to have the pass before the ministry could designate an agency as a multiservice agency. In the interim, prior to the passage of the legislation, there are other things that could happen, and there are a number of agencies and groups of agencies that are applying for proposal development grants to develop the process through which consensus is reached on how to integrate their service delivery.

Certainly that activity can happen and a number of service improvements can happen in the meantime. One example was your suggestion that a 1-800 number be established so that agencies cooperatively provide improved access, even though there may be 20 or more agencies involved. That's an example of the kind of service improvement that can take place in the interim and lead towards further collaboration and integration of services.

1400

The Chair: Dr MacIntyre, did you wish to just make a comment?

Dr MacIntyre: Very quickly, DHCs perhaps are an example. DHCs, as agencies, have been recognized for many, many years and there's no legislative statute, provision, per se outside of regulation. So I don't know why MSAs, as a construction for long-term care delivery, could not exist in the absence of Bill 173.

The Chair: Thank you. I'm afraid we're going to have to move on to our final question.

Mrs Yvonne O'Neill (Ottawa-Rideau): Dr MacIntyre, I doubt you saw my second reading speech, but many of the same questions were asked by me that have been asked by you today. I feel you've been very pointed in stating that we cannot be open-ended when we're offering services, and I unfortunately think that this bill

does give that impression, that all that has been bad will be cured. I'm glad that you've talked about the things that are good and that they are much more evident than maybe some people have suggested. I'm also very glad that you talked about the reforms in progress and that your associate Ms Cameron has brought it even further along in her remarks.

I have a two-pronged question for you. Although your brief is very specific in many ways, you didn't talk at all about the four-year interim transition the minister announced more recently and how you feel about that, and then I'm quite fascinated to see that you've taken that giant leap with the district health council to include even financial responsibility and then the accountability that would accompany that. I just wouldn't have expected that to come out of this particular brief, so maybe you can suggest why you did that and whether you think the community you represent is along with you on that suggestion for DHCs, because you're certainly the first ones that have been as specific in that recommendation.

Dr MacIntyre: I'd be pleased to respond. So far as the DHC role is concerned, I'm convinced beyond any doubt that it represents an entity whose job it should be to bring people together, but around goals and towards the purpose of steering the community in a certain direction. I don't mean in the sense of they're going to exercise choice on behalf, but that's why I use the word "negotiation." DHCs are always associated with this role of planning, but you can plan and plan and plan, and plans go nowhere. But if you plan by process of involving the local community—and those community members, those community players are stakeholders, and they know that the exercise is one that's going to govern their activities and the benefits of their local community—then I don't think planning is going to be so idle, be such a wandering or meandering effect or phenomenon.

That's why I think it's not only in relation to long-term care, nor is it a short-term view. The issue is that reform is not a one-off affair. We're into a period of turmoil that is not going to be over whether Bill 173 is passed or not. The next stage is going to be upon us, and we might find that having constructed or defined a certain continuum of care, a certain mix of services that we now categorize as the essential or the mandatory insured group of services, that mandatory coverage, it's no longer adequate and we have to establish new links.

I really think we need to focus our attention, concentrate all our effort, on coming together around some very hard economic issues, and to do that means putting a table for members to gather around but having leadership at that table for the sake of ongoing planning and negotiation. And when that activity really comes home to roost is when you've got the dollars in front of you, and that's why I'm relating it to this whole business about open-endedness.

This is what got us into trouble over medical care. Why? Because we don't have the economic view. We've defined community welfare as the sum of individual welfare, and that's essentially where I see this bill going; that is, it's a consumers' rights bill. It opens the opportunity, or at least it creates an entitlement, for people to

ask for services. But I don't find here anywhere that the collective accountability to the community resource, the total resource, is recognized. How are you going to account for that?

As far as the transition period is concerned, my short answer to that is, for your transition period is fine, but going where? What's the outcome of that? I'd like to have a sense that your transition period is going to be the opportunity that we need to get our heads around the issues at stake from our community perspective, and I'm not satisfied that that won't be pre-empted if this legislation is passed at this point.

The Chair: I'm sorry to interject. I'm afraid we're out of time and if we're to keep to the schedule we'll have to draw this to a close. But may I on behalf of the committee thank you both for coming here this afternoon and for your presentation.

REGIONAL MUNICIPALITY OF SUDBURY,

HEALTH AND SOCIAL SERVICES COMMITTEE

The Chair: I call on the representatives from the health and social services committee, regional municipality of Sudbury, if they would please come forward. Welcome to the committee.

Mr Jim Griffin: Good afternoon. My name is Jim Griffin. I'm a regional councillor from Sudbury. I'm here in my capacity as a member of the health and social services committee, and sitting next to me is Mark Mieto. Mark is the director of health and social services with our region.

I'd like to thank you for coming to northern Ontario. I guess we're all blessed with this warm weather that you see here today in Sault Ste Marie. We've had it all summer, by the way, up here in the north; no rain.

With the shortness of time, we do want to get into the meat of this, though, and express to you our concerns regarding the proposed MSA structure. On behalf of our committee at the region, I'd like to thank you for allowing us the opportunity to voice our opinion.

I want to stress that the MSA concept as a whole, at least from our viewpoint, is a sound one. I'm sure, in fact I know, that all of you sitting here today as politicians have listened to many accounts from constituents attempting to access the current system who unfortunately can only speak of confusion and some frustration.

I want to point out too that since at least 1987, we've been following this. We've been involved in it. We're not here just in passing today to comment on some legislation that is going to take place. We've been working with it. We've been working with the seniors. We have a seniors' advisory council. We as a community are at this point in time ahead of the legislation, I think.

With that in mind, I think we can all agree that this endeavour is a long-awaited, important one. It's our hope that it will be carried out thoughtfully by government and, just as importantly, will be examined and constructively commented on by the opposition.

With that in mind, we would now like to outline six major concerns that we have with the proposed bill.

1410

First of all, we'd like to see the legislation allow communities to determine who will play this planning role. Clause 1(g) of the proposed bill clearly states that

the purpose of the act is "to encourage local community involvement in planning, coordinating, integrating, managing and delivering community services." Now, it sounds great, but if you examine this closely, the legislation reveals that this purpose is not set in stone. For example, the Minister of Health recently announced that the job of planning MSAs will be given to the DHCs. We feel that if you enshrine in legislation the role of planning for the DHCs, the district health councils, then other groups or organizations may be left out of this important process.

In Sudbury, for example, at this point in time, our seniors' advisory council has historically been involved with such endeavours. Our written submission explains all of this, but I can't help but footnote on a personal level how down-to-earth, how immediately involved this seniors advisory council is, without any direction from DHC or government, but certainly through the regional municipality of Sudbury it has become a huge impact in our community with down-to-earth suggestions, a hands-on approach and really feels at this point in time it may well be left out of the planning if it goes to DHCs. That's an example of a group that feels that way.

We consulted in our community. I must admit there's no evidence that our community was consulted. I know the MSA, the structure, is going to be given to the DHCs and this is community involvement, but we haven't had any consultation up to this point with this hearing here today in this whole regard, and I just want to point that out.

Secondly, we'd like the legislation to allow communities to determine their own model of implementation. In a similar fashion, we consulted in our community to determine the type of implementation model for MSAs. The consensus was that a brokerage model should be adopted, rather than the proposed total integrated model. If communities are to play the role in coordinating and managing MSAs, why shouldn't they be allowed to determine how to do it?

Our child care system is a classic example of how a brokerage model can work, and with your permission, I'd like to pass it over to Mark just to explain briefly how we see the brokerage model working in our child care area in Sudbury.

Mr Mark Mieto: Approximately two or three years ago, we had a number of families in the community express concern about the problems they had in accessing our day care system. We had about 20 day care providers within our community, so theoretically some of the families are on one or two or could be on up to 20 different waiting lists within a community because of the 20 different agencies providing services. There were 20 sets of priorities, they had slightly different intake systems, and trying to move around from one day care system to another to be closer to work or whatever was very difficult. We recognized that as a concern within the community and we got the providers together and we started to work on it, again without any legislation and without any structure, but we did go forward as a community and we came forward with this brokerage model.

What we now have is three people working for the regional municipality of Sudbury who provide a central

intake. They do all the assessments. They coordinate all the services and put you on to the waiting list of the most appropriate child care centre. That manages a system for 700 subsidized child care spaces, and you can appreciate there's a lot of in and out in the system, so it manages a fairly complex process for the community.

Also, the prioritization, the intake and all of that has been worked out with a community planning body which provides for the providers, the consumer advocates and others to be involved, and we've received a lot of valuable input from that group in terms of setting the priorities and the allocation mechanisms involved in this process.

It just illustrates that there are other models that can work in a community in a social services or a human services setting, and I guess what we're saying is it also allows for a decentralized delivery, meaning that the 20 day care agencies are still intact, many of them run by volunteers, and allows them to be fully participating in their agencies and their organizations. Again, that certainly reflects, from our perspective, the model, that brokerage model, would go a long way to meeting the original objectives of this legislation.

Mr Griffin: We're not saying that's the only model. It's an example of a model that is brokerage in nature which could be used, and certainly all we're asking is that the flexibility be placed in the legislation to allow that type of dimension.

Thirdly, we'd like you to reconsider the four-year deadline. MSA restructuring, I don't have tell you that, is going to be a complex, time-consuming process, and while some communities may be able to reorganize in two years, others may take an awful lot longer. As you are aware, regional differences exist within the province. The degree of services differs vastly within the province. For example, from north to south, you're all well aware of, I think, the problems we face in Sudbury and in northern Ontario with delivery of health care services. Possibly, Mark, you could speak just to the degree of services.

Mr Mieto: Again, just to maybe give an example of that, I'm aware of certain service delivery agencies in Metro Toronto where there's an executive director, a finance person, perhaps one or two professionals in program administration and the delivery agencies. I can think of similar agencies in Sudbury where the executive director is the sole person who answers the telephone, coordinates the services and, if no volunteer shows up, they will jump in their car and go provide the service. That's the same agency. So there are differentials when you talk about one program in an urban setting versus something in a rural setting. You can't use a blanket approach to these kinds of settings. You have to understand the realities within communities.

Mr Griffin: And we'd like to see that reality reflected somehow within the legislation.

Fourthly, we'd ask that we eliminate the 20% limit on services purchased. I'm aware of a number of presentations at your public hearings in Toronto, and this point apparently came up a number of times.

If the services are being delivered efficiently, then why phase them out and allow government to deliver them

all? Many problems may arise, in our opinion, if the MSA becomes this huge manager and deliverer of important services. We find the 20% rule arbitrary. There's an inherent conflict of interest here that we can see.

We understand that all of these agencies have administrative costs. They have administrators, financial advisers. They may well run to duplication. But it's very important that before the legislation comes into place, you weigh the cost of losing the potential loss of volunteer help against the apparent cost of these administrative features in the different small agencies, or member agencies.

There could be a perception, as we see it; the groups may perceive that the MSA is running everything, and if the MSA is doing it, then why volunteer? Like in Sudbury, the Meals on Wheels is really one person delivering thousands of meals with several volunteers, hundreds of volunteers. There's literally little or no overhead or administrative cost to that. But would those volunteers remain there if the MSA, a government agency, perceived as a government agency, was taking over the administration of Meals on Wheels?

In the north I think in particular—and I say that without a knowledge of the south—we feel that there's a potential there for all of these volunteers to dissipate, to lose their interest because they feel government's going to do it.

The local community should be able to determine this ratio themselves. If it's 20, if it's 80, if it's 60, like, who cares? What's the difference? You're taking an enormous risk by assuming that the thousands of volunteers will continue to work and continue to function if the MSA does it. Therefore, eliminate the 20% rule.

1420

Fifthly, we'd ask you to consider adopting AMO's position on governance. I'm sure you're all very likely aware of AMO's views re the MSA. If not, we've refreshed your memory by outlining their position on governance in our written submission to you, with all due respect.

The most important point, as we see it, that AMO's trying to make, which we fully endorse, is the following: Municipalities are a level of government with a proven commitment to providing long-term care services. As such, we feel that municipal governments should be provided with the right of first refusal to govern local MSAs and to determine which model is appropriate for their community.

Sixthly, we'd like you to consider the consequences of appeal board decisions. As it stands in the legislation, the appeal board is very powerful, so powerful that enshrined in legislation is a clause which makes their decisions irrevocable. Well, this finality clause, as we see it, could have serious ramifications on delivering long-term health care in local communities.

Mark, we have an example, and it's only one example and a very simple one, but I think it illustrates clearly the potential damage that could be inflicted if this appeal board process is not thought out carefully.

Mr Mieto: I was just going to explain that in our community we dealt with a discharge from one of the chronic care facilities and the family was very interested

in having that person within their own home and the person required very extensive 24-hour services. When we were looking at it from our integrated homemakers program, it would have absorbed almost 60% of our budget for one individual, which had historically been involved through a history of a process in developing some criteria for it.

Ultimately, the area office was able to make special arrangements for that case, but in essence, if the appeal board has a final determination over an MSA board, a potential example that one could see, a scenario—and this is assuming that there will be limited funds given to an MSA structure at some point—is that if an appeal hearing were held, perhaps on four or five different persons who required new services in a community, and no appropriate funding were given to that MSA, that MSA board could have been working on an expansion to, let's say, a Meals on Wheels service where volunteers were trained, arrangements were made and individuals were ready for the service. As an MSA board, you're out there saying, "Yes, we're going to launch this service," and meanwhile you just receive an appeal board hearing that orders you to pay out, let's say, \$400,000 or \$500,000. Where is your credibility as an MSA structure to be truly involved in planning and delivering services?

Somehow, someone has to work out that either for one year after this board makes a ruling, funds are provided, so that the financial flexibility and the planning capabilities are not eroded by this special appeal board—some provision has to be made for that, because otherwise the MSA structures will not have credibility at the local level.

Mr Griffin: You can imagine the feeling locally if decisions are made and through the back door all the decisions that are recognizable as being made by the MSA and the community suddenly are changed and reversed and the community knows that. They'll know it the next day.

Let me conclude by saying that as members of the Legislature, you have an arduous yet important task ahead of you. The creation of such an MSA structure has been long awaited. From our viewpoint at the regional municipality of Sudbury, please proceed. We believe in the basics of all this. There must be some vehicle by which this whole process can evolve. There must be some starting point, some central focus. If adopted, this system obviously is going to affect thousands of Ontarians. It's hoped that all the suggestions and comments you hear throughout the public hearings will be considered as you enter into the clause-by-clause deliberations.

On behalf of the region of Sudbury's health and social services committee, we would like to thank you all very much for your attentiveness and for the opportunity to express our views here today. At this time, if time permits, Mark and I would be more than happy to answer any questions you may have.

Mr Larry O'Connor (Durham-York): I appreciate you coming from Sudbury. I spent a lot of time in my youth north of there in Capreol and consequently in the flats near Garson picking a few blueberries in my time with my nine brothers and sisters. It was a good pastime. It also got us out of the hair of my mum and dad, I guess.

There has been a lot of work gone on as far as health care delivery for home care and what not in Sudbury. I'm sure you're all proud of the integrated homemaking program, over \$1 million committed there that's been annualized, \$15 million now into home care, I think, this year's budget—incredible. The district health council has an allocation for supportive housing of half a million dollars I believe it is. So there's a lot happening there.

Earlier we heard from people representing, again, parts of the large rural north, and I represent rural parts of two large regional municipalities down in southern Ontario. Durham-York's the riding, so a little bit of Durham and a little bit of York, but the rural parts. I wondered, with consumer representation and what not, how then you could see the cooperation. I guess you probably have it with your senior advisory committee. How do they work, given so large an area, with some of the decisions you've come to us with, some of the suggestions you've come to us with, because my understanding is that the seniors' advisory council does work with the long-term care area office and has been working with the long-term care committee with the DHC and there has been some cooperation there.

I just wonder, because you seem to point a different view and pose it a little different way, maybe some of the rural parts, which was pointed out earlier as a concern, not being reflective of some of the decisions. How do we make sure consumers in those parts are fully represented in the care that they need and we want to make sure they have for their future as we proceed with this redirection?

Mr Griffin: I don't know if I have answers in terms of distribution by population or just number of users. It's a difficult question and I see what you're going to be faced with when you try to do that. We're all consumers, and I guess we tire of having segments of society represent because they're a minority or because they're a segment, and yet we all are or will be consumers of this whole process.

Mr O'Connor: I can't consider myself a consumer of long-term care services right now, in all honesty, and very few of my local municipal representatives are in fact really seniors so they could consider themselves as consumers. But your advisory committee that you mentioned: Is that representative of the whole area or is it based in Sudbury? How broad is that?

Mr Griffin: It's representative of the whole area. You're familiar with the Sudbury area. The chairperson was from Walden and there are members from Capreol and all of the different small municipalities. They have meetings both in Sudbury and in outside municipalities. So they are representative, and I think it's on a voluntary basis. There's no commitment on that advisory council, as I recall, Mark, for two to be from this area, one from here, is there? It's basically representative.

Mr Mieto: It's geographic but primarily the structure was set up to represent the almost 80 seniors' organizations and there are about 16 or 20 members who represent those other organizations within a community. Its sole focus and its board of directors is strictly consumers, although there is a special advisory committee of service providers to provide that professional expertise to the consumers who would be on the advisory council.

1430

Mr McGuinity: Gentlemen, thank you very much for your presentation. I particularly enjoyed learning about the way in which you dealt with your regional day care and developed a regional day care program. I think it serves as a very good example for us in terms of the kind of approach that we might bring to the problems connected with the delivery of long-term care service in the province.

I don't really think I have a question so much as a comment to which you may wish to respond.

The Chair: None the less, a brief comment.

Mr McGuinity: None the less, a very brief comment, Mr Chair. The government seems to conceptualize—let me put it this way: I think one of the strengths on which we should be capitalizing, one of the strengths we should be harnessing, is the way in which long-term care in this province has continued to evolve and to adapt to meet changing needs. I see that as a strength.

Now, there is undoubtedly something there that's missing which government can supplement, and I think that's by resolving the accessibility problem. But I don't think you kill the damn animal which has served us so well by adapting to a changing environment and replace it with something that is perfectly static. My concern is if we come up with the MSA model, and that's to be the be-all and the end-all, what do we do if it doesn't work? We've eliminated its ability to continue to evolve and adapt.

Mr Griffin: That's exactly why we say that the example we used is only an example. It may not work in Chapleau, Ontario, or it may work in Chapleau, Ontario. That's why the flexibility has to be within the legislation. If it's working, why fix it? That flexibility has to be built in. That's a good point, and I build on that. That's exactly where we're coming from.

The Chair: I regret that time flies by in these hearings, and I'm afraid we are going to have to move on. We do appreciate very much the regional municipality coming before the committee. It is always good to see you.

ALGOMA HEALTH UNIT

The Chair: I then invite the representatives from the Algoma Health Unit, if they could come forward, please.

Mrs Barbara Sullivan: Mr Chairman, as they're coming forward, I wonder if I could request that the ministry—perhaps not at this time, because we are pressed for time—brief the committee on how it envisages aboriginal concerns, including those that are associated with geography, encompassed by the MSAs, particularly those combining the spiritual, the health and the cultural needs of a remote geographic area with the purchase of specialized services such as speech-language pathology and so on, which are included as mandatory services, or even the trainer funding. I think that we would all appreciate that kind of a briefing.

The Chair: We will work that out. I'll discuss that with the parliamentary assistant.

Welcome to the committee. If you would just be good enough to introduce yourselves, then please go ahead with your presentation.

Ms Gail Russell: My name is Gail Russell. I'm administrator of the Algoma home care program.

Dr Allan Northan: My name is Allan Northan. I'm the medical officer of health for the Algoma district.

You may have a copy of my presentation. I'm just going to go through it as it's laid out, and you can follow it with me. I started off by saying that long-term care reform is meant to address the following, and there are five items there.

The first one is one-stop access. I would perhaps like to look at that more as improved access, because one-stop access gives what some people have said is a sort of feeling of unreality, that something's there that won't be there. I don't think it'll always be easy in something as complex as long-term care to just pick up the phone and have everything solved at once. So if it's made to seem that simple, I think that's an impossibility. But I think improved access should certainly be stated as a goal of long-term care reform.

The second one is improved community-based services. I really think the services that we have in our community are basically excellent, and I'm talking from experience working in Sudbury and also here in Algoma, that the services are excellent. I think what we're probably trying to say is improved coordination, and I think there probably is some improvement in coordination that could occur.

The third thing that long-term care reform is meant to address is a consumer-focused system. I guess I'd have to ask: What has the system been focused on, if it hasn't been consumers, for all these years? I think we have done a good job for the consumer. One of the things that has paralysed us, or caused us problems, in home care are the rules and inflexibility that were built into the system; not something that was designed locally, but was a provincial entity. I think that is something that's easy to address.

The fourth thing was improved, consistent accountability. I think the accountability has been as good as the services that I've talked about, and again, it may be the coordination of those accountable that we're talking about.

The fifth one is local community-controlled planning through the district health council. I think, in my mind, that's a little bit, again, painting a picture that's not completely true, because it's not, as it's gone so far, local community-controlled planning, because there's been a large amount of central planning and central control. The broad plan has come centrally from the province, and the district health councils have been asked to facilitate that plan and to work out the details of that plan. But, as some speakers have said, there hasn't been that flexibility to design the local system of choice; it's within the parameters, the plan that the government set out.

What needs to be done to achieve the above goals, those five things that we're addressing? There are really three things to look at that are on the table right now. There are MSAs throughout Ontario, which is what is being proposed in the legislation. I would suggest another alternative is a pilot MSA to look at this more closely in a more experimental way. The third one is more flexibility in existing agencies plus collaboration among agencies, or what people are starting to talk about now is the federated model of all the services working together in a more closely aligned collaboration.

I guess you could have a fourth one and say change nothing, but I think we all agree that there is room for change, and change for the better.

I'll look at those three choices one by one. First is the MSA. Would an MSA achieve the goals set out better than either what's in place right now or some of the other alternatives? I don't think it would. Would an MSA be less expensive than the present system or a federated model? No. If you consider the cost considerations, one thing is that you'd probably be looking at new offices, especially if we're talking about multiple MSAs to replace the approximately 40 home care programs and associated services in the province.

You'd have a lot of new offices to begin with. Former offices, for example, would not have common compatible computer systems; you'd get into that kind of issue. There'd certainly be serious staff issues. Remuneration to the highest pay levels would be one thing that you would have to deal with as you put all these component agencies together, and that could cause a lot of chaos and inequities throughout the province. Union contracts would be expected to go to the highest benefit levels and so on. I think the first few years of this kind of solution could result in much attention to process and less to program delivery. In my mind, I'd be worried that we might not get what we wanted.

I guess another question is, is a monopoly of services the answer? I don't think so. I always believe that incentive is important, and I think this system does challenge the whole incentive issue.

Is there presently an agency in place that is suited to take on the MSA role? I mention this one particularly because—and Dr MacIntyre had the same concern—Bill 173, for some reason, states that health units would be looked at only in terms of a last resort; all other possibilities would have to be looked at before health units were chosen to be an MSA. So if we had to have MSAs, if they are necessary, I want to refute that part of the legislation.

Health units would be a logical first place to consider. First of all, the infrastructures are in place with health units, and some health units right now are actually close to the MSA that's envisioned. Health units have case management, they have the health professionals, such as the physios, the OTs, the speech-language pathologists, social workers, dietitians, and some health units have their own nursing services.

In particular, in terms of nursing services in the north, Sudbury has its own nursing services in Chapleau and Manitoulin Island, so it's already doing that itself. Here in Algoma we have our own nursing services in Elliot Lake. The purchase-of-service nursing services have not chosen to take on the areas that we have, because they're in the remote, hard-to-staff areas. But the health unit, because it was accountable and responsible for the service, has had to provide the nursing services.

1440

There is expertise, and I can use our health unit in particular as an example, already in place in the health unit. First of all, there are 20 years of expertise of the staff involved. There's management experience. Myself, as medical officer, I've had six years with the long-term

care area, and I have a background in rehabilitation medicine as well. Our business administrator was the former home care administrator. She is now in charge of the health unit's business administration, is a nurse by background, but also has a CMA and an MBA and is well-qualified.

Our home care administrator, beside me, Gail Russell, is very competent and runs the program at present. One of her assistants is a former VON executive director, who ran the VON in our community. So we have a wealth of experience in the agency. Also, the agency is strong in terms of prevention, promotion and evaluation. In terms of service delivery, we're moving to extend our hours further and heading towards the 24-hour-coverage concept in time.

I'll come to the governance issue, which has been raised. I'm sure, since I'm one of the later speakers, you've heard a lot of these arguments before and things will be contested both ways. But I think in terms of governance, our board members for health units are quite capable of being a board. First of all, many board members are elected officials, and they're elected by and for the people. These elected officials are ones anybody can go after in terms of concerns, complaints and so on and have much more leverage because those people are elected. Anything that they put in the press, in editorials and so on, has a lot more leverage on a board member who depends on being re-elected than on somebody who's appointed to the board.

The other thing about board members is, I'm sure if boards of health were surveyed, I strongly suspect the majority of the members of all 42 boards of health in Ontario would have experienced significant personal exposure to long-term care situations, even if they didn't have the services themselves. I'm sure almost all of us have either elderly family members or others in our family who have received home care services, and we know very well what the problems are and can be.

The second choice was the MSA pilot. The reason I look at the pilot is, as I said, I think the MSA concept for all of Ontario is quite a megaproject, and a pilot of the MSA concept would make sense, to me at least. If the pilot turned out to be a Titanic, then at least the province wouldn't have a whole fleet of them. I think that analogy is important, because you're going to be in an awful mess if this whole thing blows up in our face and our whole system is sinking. That's probably too dramatic. No matter what we do, it's too good right now to make changes and sink it, but we could bring it back a few steps, and that would not be useful in a time of economic restraint with all the needs that are out there.

In terms of the third choice, the federated model is being talked about now in terms of what Dr MacIntyre was asked about in terms of that interim delivery model. The federated model is supposed to be a collaboration of component services of the proposed MSA. I think that the agencies are willing to work together right now. My feeling is that perhaps the lever of all this intimidation of forming MSAs and so on has made a lot of agencies that in the past did not talk to each other, as they should have, much more ready to discuss issues that are in common, and that is the consumer.

A coordinated system of agency service delivery would be paramount. I think physical collocation of agencies would, where feasible, improve communication by virtue of easy accessibility of agency staff.

The other thing about a federated model is that the messy amalgamation of employees with varying labour contract backgrounds would be avoided. I think that one is going to be an enormous headache if the MSA ever goes ahead. I just can't see how all the varying backgrounds of labour contracts are just going to come together, and I don't know if anybody has even looked at that. I'd be very interested to know what people have thought about that, because that will be messy.

Morale of staff resides in part with agency heritage, and a federation would not wipe out agency heritage.

On page 18 of the question and answer section on Bill 173 that the Ministry of Health put out in June 1994, the following is quoted:

"Under the new legislation, there will be no requirement that services must be provided only on a visitation basis or in hourly allotments. This will make it possible for care providers to tailor their care provision to fit the consumer's needs rather than adhering to rigid, inflexible program rules. This increased flexibility will make it possible also to provide essential respite for family care providers when they really need it."

I think that above change is the crux that needs to happen. I've felt for the years I've been involved with home care and long-term care that the inflexibility of rules has hampered our ability to deliver services to the consumer. That one statement within the legislation is key. If the whole legislation falls, I hope that part does not fall, because that's critical, that there be the flexibility of service delivery.

That basically is my presentation. In summary, I've basically said that the MSA is not the proven way to go. If we need MSAs, health units I think really should be considered very seriously because of their wealth of experience in that area. If the MSA model is the way the government wants to go, I think a pilot should be seriously considered before we embark on the whole thing. I've talked about governance, and I'm not going to rehash that. My feeling is that perhaps at this time it would be recommended that a federated model provincially would be my way of going, and at the same time, if it's felt necessary, a pilot MSA could be started to see how that works out.

Mr Jim Wilson: Thank you for your presentation. The federated model has been discussed by a number of presenters to this committee. I don't think we've ever asked the government why in essence it has rejected that model, so I'll place that question to the parliamentary assistant at this time.

Mr Wessinger: Perhaps the first thing I should say is that a federated model under the legislation is permitted during the transition period. But at the end of the four-year period, after the MSA is designated, of course, it has to evolve into a completely integrated model.

I think if we look at the definition of a federated model, a federated model still would involve each of the agencies continuing with its own administrative structure. As a result of that, you would not have the cost savings

that could be effected by common administration. I think this morning we had an interesting presentation from the two hospitals in this area. We had evidence that \$2 million in savings resulted from the coordination of management and administration. It's certainly very much a policy of this government to encourage more cost-effective delivery.

I think the other aspect that I might indicate is the whole question of the inefficiencies with respect to the different agencies delivering different services. It's certainly the evidence before us by one of the multi-service agencies that existed, I believe, in the county of Victoria that they felt it was much quicker decision-making and a better, more streamlined process having a single agency rather than having the non-communication between the various agencies.

A third aspect is the whole question of accountability. I think it's very much a principal part of this legislation that we have a board that is community-based and is responsible to the community. How do you achieve that in a federated model, particularly if some of the models in the federation aren't bodies that have local governance?

1450

Mr Jim Wilson: I suspected that I would hear parts of that answer from the parliamentary assistant, but if you're so sure that your new MSA bureaucracy is going to save money, why can't you provide this committee with one iota of evidence to that effect? You've not told us what the current, mostly volunteer structures out there now, the current agencies, what that's costing. So we don't know what the benchmark is right now. You haven't told us what the cost of new MSAs is going to be.

In fact, all of the evidence to this committee suggests that we're heading into a new large government bureaucracy much like mistakes that have been made in the past 20 years by governments when we've amalgamated municipalities ad hoc throughout the province or amalgamated school boards or whatever. Now we're doing it in health care. If you're so sure, why can't you provide any evidence to this committee so that we're not doing this without some actual fact?

Secondly, with respect to accountability, and maybe the witnesses want to comment on this, you've just been told by two boards of health which have elected officials on their boards already that you've got direct accountability. The example given by the witness here about the leverage that consumers have on elected officials is far more than they're going to have on anonymous bureaucrats in the MSA. So I don't see the basis at all, Mr Wessenger, in fact for the approach you're taking. The witnesses may want to add something.

Dr Northan: About the cost especially, where you're using a hospital analogy, I think it's a bit dangerous to externalize one experience to another. Hospitals are two like entities, where they've got multiples of, say, director of nursing, director of this, director of that. What we're talking about are unlike services coming together, where expertise will still be needed to run these various areas; like homemaking will be run by somebody and still will need to be and so on. So you're bringing a lot of unlike

things together that will still need to be run by people who understand the running of these components. So I'm not so sure that you're going to see the kind of savings you might have seen in a hospital merger, for one comment.

Mr Wessenger: Could I just comment?

The Chair: Briefly, please.

Mr Wessenger: This is more in general terms, but certainly part of the parameters of the local planning community is to look at the cost-effectiveness of the new structure. That's one of the criteria that they are to use when they're recommending a structure, to ensure that there will be this cost-effectiveness and these cost savings. So I would assume that if the long-term care committee came to the conclusion that there was no cost-effectiveness in the new structure, then it wouldn't recommend a new structure.

I think the other thing we should remember, that perhaps is a misapprehension here, in a sense, is that with this legislation, when you're talking about pilot projects, it's not anticipated you're going to have MSAs established at the same time in every community across Ontario. It's obviously going to take a period of time to evolve, and it should be remembered that the four-year transition period starts from the time an MSA is designated. For instance, you may have an MSA designated, shall we say, in this community next year. On the other hand, in another community it might be two or three or four years down the road before you'd have an MSA designated. So I think we should remember that, that the legislation contemplates that type of approach.

Dr Northan: I'd still like to see a pilot project prove your point. I don't think it's proven that an MSA will be as cost saving as you suggest, and I think a pilot is a wise way to go. I don't see the rush.

Mr Martin: I just want to thank you for coming forward and for your very thoughtful presentation today, and to say to you that certainly the experiences that you have had, the delivery of service that the health unit in Algoma reflects, are some of the good things that we want to build on in this new model. That's why we're bringing people like yourselves together on these coordinating committees and boards, especially the one that presented before lunch.

I recognize the fact that you sent me a letter a few weeks ago, very pointed in terms of why you were not being considered to be an MSA if in fact one agency was chosen. I wanted the ministry people to perhaps respond to that question so that I don't have to relay that to you. You'll get it from the horse's mouth today as opposed to through me, although I suppose politically you're looking for a commitment from me to maybe some further action on that.

Dr Northan: Just an explanation.

The Chair: Which horse's mouth were you intending?

Mr Martin: In line with that question, I found it interesting that on the one hand you were saying that MSAs probably wouldn't work, because they would just be too big and unwieldy and the efficiencies wouldn't accrue that we're expecting, and on the other hand, though, you're saying that you in fact do operate now

very much as an MSA; that you deliver a host of services across the region and that if we were going to consider an agency in this area to deliver it, you'd probably be the most logical one to pick.

I suggest to you that the VON could make the same argument and the Red Cross could probably make an argument very similar, and that in fact is the reason why we're trying to pull together the groups so that we might in this area move away finally—the term was used this morning “bite the bullet” around the question of who's going to deliver the service, how it's going to be delivered in a consistent, equitable fashion across the province and Algoma, so that in fact we are focused on the consumer as opposed to our own organizations and their continuance into the future.

But I'd like to ask the ministry, if it would, for me and for Dr Northan here, why it is they were put at the bottom of the list in terms of being considered for an MSA.

Mr Wessenger: Okay, perhaps I will give the answer, and I'll give Mr Quirt an opportunity to elaborate, because I may not cover the whole aspect. I think there are two problems with respect to a board of health. I think first it's a governance model in the sense that, how do you ensure in the governance model that you have consumer representatives and also have that input of health providers and social service providers which you want in an MSA? So that's one of the problems.

If I might just add a personal observation here—I think I'd have to say it's personal, because I don't want to tie the ministry with this observation—I think certainly in my discussions with many medical officers of health, a lot of them have some concern about the present governance model in the sense that the body that's providing the majority of money is not accountable. In other words, the provincial government provides the majority of money for boards of health, yet the control of them is vested in the municipality. So it's a problem with respect to the whole disentanglement aspect, and that's, I know, related to boards of health.

The third aspect of concern is, would a government body, a board of health, have the same ability to bring in volunteers? I think that's something we should ask the boards of health, because I'd like to know whether they in fact feel they could successfully incorporate the volunteer programs.

Of course the last aspect is, seeing that they're not a charitable corporation, although there might be deductibility for the donations, how successful would they be at raising donations from the private sector?

The Chair: I'm going to ask Dr Northan if he'd like to comment on that. We are tight for time, and I'm afraid we'll then have to move on.

Dr Northan: Okay. I guess as far as taking care of volunteers, I don't see that as a problem. If one agency can do it, so can another. In fact, we have a volunteer coordination system within our health unit, and we get a lot of good work out of volunteers from the community. So we already do that.

As far as being a charitable organization, our health unit isn't, but I understand that Porcupine Health Unit is, so health units have done that before too. So it's not

something that's impossible to do; they've done it. Most health units haven't done it, because of the complexities involved. But if you've got the reason to do it, enough merit out of going through the agony of becoming a charitable organization, then, sure, we're quite equipped to do it if we had to.

I guess I say, though, I've been terribly concerned over the whole governance issue, because I don't see this as key to the service delivery. I think no matter who you've got on the board, you have intelligent, committed people, and I think we're all touched by long-term care issues. I think elected officials have other reasons, just being elected, for being good board members. But if you get consumers who have their own specific experience with long-term care, are they necessarily going to be good for the system when they bring their one or two particular concerns about long-term care with them to the board?

Board members are not supposed to be focused on certain issues; they're supposed to look globally at the whole picture. I think that's a quality that you'll want with people. I've seen some board members who have consumer issues who get very focused on things that are very key to their own lives, and that's something that board members have to try to avoid. I think good board members will avoid their own personal stake in it and look at the broad picture.

1500

The Chair: Thank you, and for a final short, sharp question, Ms Sullivan.

Mrs Barbara Sullivan: We know and we have spoken at some length with respect to the lack of feasibility studies both on cost benefits, cost-effectiveness, service improvements, outcomes measurement that could be achieved through an MSA as envisaged through this bill. The government has so far rejected a pilot project. I'm going to ask government officials now if they will consider a pilot project to ensure that those measurements are taken. Indeed, one community can be used as a basis for observations about the cost-effectiveness and feasibility of the MSA model that's being put forward.

Mr Wessenger: It's certainly not anticipated there would be what we call pilot projects, but as I indicated earlier, we foresee MSAs developing at different rates across the province, and obviously there'll be assessments from the early developments and they'll influence the later developments.

Dr Northan: Could I make one comment here just about the whole administrative issue and the cost related to this pilot? One of the things you said is that amalgamating will save money because two hospitals are amalgamated into one.

One of the problems with the MSA concept, I know in our district, is that we've got a district-wide system of running our home care services now through district agencies. At least, a lot of our services are run that way. With the MSA concept, at least this district is looking at maybe four, five, six possible MSA sites. If that happens, if it comes out that way, I don't know how it's going to work out if it comes about.

Say we get six MSAs in this district where we had single-district systems. That administrative saving that you're talking about isn't obviously there in my mind. I

agree with the last comment, that a pilot would have to look at this and look at the scope and the size of this thing and how much administration per capita and so on. If we end up with six or seven MSAs in this district and right through the province, and instead of having, say, 40 systems we've got 500, to me we're going to be into a cost overrun.

The Chair: Thank you. Again, I regret as Chair I have to play the heavy and bring this discussion to a close, but we do want to thank you for your presentation and answering our questions today.

ALZHEIMER SOCIETY OF SAULT STE MARIE
AND ALGOMA DISTRICT

The Chair: I invite the representatives from the Alzheimer Society of Sault Ste Marie and Algoma District. I believe members have a copy of your submission. We want to welcome you to the committee this afternoon.

Ms Brenda Lailey: My name is Brenda Lailey. I am the chapter administrator for the Alzheimer Society of Sault Ste Marie and Algoma District.

Ms Maria Bell: My name is Maria Bell. I am a member of the Alzheimer association and a care giver of an Alzheimer patient.

Ms Lailey: As administrator, I'm pleased to be able to attend to today's hearings on behalf of persons with Alzheimer disease who are often unable to speak for themselves. Maria, a family care giver and a member of the society, will speak later.

We're here today to discuss with you some important factors and concerns that we have as family care givers, volunteers and staff members of the Alzheimer society. In brief, we would like to highlight some important information concerning Alzheimer disease, discuss some principles of long-term care reform in conjunction with care for persons with Alzheimer disease and make suggestions for how the principles of Bill 173 can be implemented to effect positive change for persons with Alzheimer disease and their care givers. As well, Maria would like to share with you her personal story.

Alzheimer disease is progressive, degenerative and exacting in its effect upon the person. It turns formerly self-reliant human beings into dependents without dignity, humanity and memory. Care givers, who are usually family members, must cope with emotional, financial and physical stress, often without respite in a gruelling 36-hour day.

The recently completed Canadian Study of Health and Aging reveals that 8% of Canadians aged 65 or over suffer from dementia. Of these individuals 5.1%, or almost two thirds of all dementias, have been identified as having Alzheimer disease. The study further reveals that 26% of persons aged 85 or over suffer from Alzheimer disease, and in Ontario more Alzheimer persons currently reside in institutions than in the community.

It is anticipated that the number of cases of Alzheimer disease in Canada will double by the year 2021. Recent figures released in the United States indicate that Alzheimer disease is the third most costly disease. The costs for providing care for Alzheimer persons are

exceeded only by those associated with cancer and heart disease.

At present, there is no known cause or cure for this disease that robs the mind of a lifetime of skills and memories. There is also no effective treatment to alter its progress. Following diagnosis, Alzheimer disease can progress for a period of from two to 15 years. During that time, the Alzheimer person will depend more and more on a variety of care givers, both family and professional.

Because of the progressive nature of the disease and the potential for many years of care, it is essential that adequate community support systems be put in place to meet these needs. Without access to readily available and adequate respite services, there is concern that the Alzheimer person may require premature institutionalization. In addition, the burden of care required to maintain an Alzheimer person at home often takes a heavy toll on the primary family care giver. Without adequate support, the care giver's health deteriorates and the ultimate result is two persons requiring long-term care.

Our comments around one-stop access: The Alzheimer society supports the multiservice agency concept with its focus on a one-stop shop, the availability of basic services across Ontario and local design of programs to meet local needs. We are concerned that in meeting the admirable goal of consolidation and integration of programs, the needs of both family care givers and people with Alzheimer disease may be lost among the competing interests of other consumer groups. This will, we fear, be compounded by both cost containment and misconceptions about suitable services to the extent that our constituents will be put at risk.

It has been our experience that family care givers of Alzheimer persons are often reluctant to reach out for assistance. Inevitably, it takes a crisis or breakdown in the care giver's health to precipitate the search for assistance.

The Alzheimer society treats these families as a priority, offering a quick and personal response to their plight. This is achieved through education and awareness about the disease, care giver support groups, referrals for respite homemaking, the wandering person registry, the volunteer companion program, as well as in-home activity therapist services and the Alzheimer day away program where appropriate. It is our hope that should future assessment and referral of dementia persons be conducted by the staff of the MSA, these front-line workers must be sensitive to the emotional needs of care givers and also be able to respond quickly.

We further recommend that sufficient funds should be made available in all MSAs whereby personal reassessments of the condition of people with progressive neurological diseases are done on at least a twice-yearly basis and service plans are adapted to meet the changed circumstances.

Likewise, when an Alzheimer family approaches the MSA for assistance, it is recommended that the assessment staff refer that family to the Alzheimer society for specific information about the disease and additional

support as a part of the overall care plan for the individual. We further recommend that a formal referral process be put in place, including the necessary client assessment information, so that the individual needs of the Alzheimer person and his or her family care givers can be identified and addressed without delay.

1510

We are indeed please that both homemaking services and adult day programs have been identified as core services in the proposed legislation. Both of these services provide respite for the family care giver as well as an opportunity for a trained individual to involve the Alzheimer person in meaningful activities which focus on his or her persisting strengths rather than on the deficits resulting from the progression of the disease.

It should also be recognized that respite care is essential for care givers of Alzheimer persons. At the present time, the Alzheimer Society of Sault Ste Marie, in conjunction with the Canadian Red Cross Society, administers a budget of \$60,000 for the provision of respite care for Alzheimer families throughout the district of Algoma. With the inception of the multiservice agency concept, it is vitally important for Alzheimer care givers to be able to continue to access this source of additional respite care.

Concern exists for those families attempting to maintain an Alzheimer person at home who do not qualify for respite homemaking or who are already receiving the maximum 60 hours of homemaking currently available through the home care program.

For families requiring night-time supervision of a person at risk for wandering, the 60-hour maximum provides for a mere seven night shifts per month with next to no hours left over for daytime relief. Because of the intensity of care required for an Alzheimer person, how will these care givers be able to access sufficient respite services in order to avoid premature institutionalization because the family is unable to cope with what is so often referred to as a 36-hour day?

At the present time, the Alzheimer respite homemaking program provides respite care to 23 families in the district of Algoma, and 17 of these families also receive homemaking services through the home care program. If these individuals continue to require the same level of care until March 31, 1995, ie, the end of the current fiscal year, there is a projected deficit of approximately \$7,000. As a result, we will be unable to meet the present demand, and service for those already registered will have to be reduced. As well, any new requests for respite assistance will have to go on a waiting list. To illustrate the current demand, during the months of June, July and the first three weeks of August of this year, 22 new families have approached the Alzheimer society for information and assistance. We anticipate that this trend will continue because of the greying of the population.

The board of directors of the multiservice agency will have a responsibility to ensure that the dollars allocated to their funding envelope are spent wisely. If large numbers of individuals requiring long-term care are Alzheimer persons, then we would submit that the planning should reflect this need.

Further, because of the long-term progressive nature of Alzheimer disease and the specific deficits it causes, the Alzheimer society continues to see difficulties in meeting the needs of people with Alzheimer disease through generic community-based services. Indeed, the association finds that placing people with Alzheimer disease in integrated adult day programs can be simply another form of institutionalization.

It is the society's belief that the specialized Alzheimer day program currently offered in conjunction with the F.J. Davey Home is of vital importance and should be continued. Through specific activities, the program maximizes the remaining skills of persons with Alzheimer disease and related dementias, thereby prolonging residence in the community.

The Alzheimer society commends the government for the development of a system which includes the recognition of both people with Alzheimer disease and family care givers as separate consumers of long-term care services. Since an individual suffering from Alzheimer disease or a related dementia is seldom the one who requests service and is often not capable of making his or her own decisions, it is imperative that the primary care giver be afforded the opportunity to participate in the preparation of a suitable care plan, regardless of whether a legal authority exists.

The legislation requires that the composition of the board of directors for a multiservice agency "include consumers and other members of the community to reflect the diversity of the population served." Recognizing that to this date no consumer group of people with Alzheimer disease exists from which representatives may be drawn for appointment to long-term care planning or service delivery bodies, but that care givers of people with Alzheimer disease are themselves consumers of different long-term care services and maybe substitute decision-makers who have been chosen by people with the disease, we strongly recommend that MSA boards include people who have been directly affected by the disease.

The legislation also provides an opportunity for "consumers receiving community services" to "appeal certain decisions made by an approved agency providing services under the act," and that such "appeals will be heard by the Health Services Appeal Board." Concern exists regarding the length of time required to permit such an appeal process to take place. It is our recommendation that a local appeal process be established for review of any service delivery decision with which a consumer is dissatisfied.

It is our position that one-stop access to information and referral will be a positive step forward for individuals seeking assistance with the care of an Alzheimer person. It is our hope that the expertise and support currently provided by the Alzheimer society will continue to be an integral part of the care plan for all dementia persons and their care givers.

Ms Bell: I would like to thank you for allowing me to speak on Bill 173, addressing the concerns that I have as a consumer and a member of the Alzheimer society. My concerns are similar to those in my situation who

cannot speak for themselves or who do not have the makeup to do so. It is for these two reasons that I feel one-stop shopping is a great idea.

My mother and I did not spend a lot of time together before the onset of this disease, and therefore making the decision to seek help for her, when my father was not able to even see the problem, was very difficult for me. Because I lived in the part of town that directed me past the Alzheimer office every day and because I knew them from my work, which is taking donations at a funeral home, I identified them as a source of help for my situation. After almost a year of contemplation, I finally went in to get some information.

I was fortunate that these two avenues were available to me. To most others they are not, therefore I feel it is important that the public be educated about the help they can receive. The Alzheimer society was a haven for me and for many others, regardless of our situation. I feel that they are a necessary association to be a part of the total health care plan.

My father is 78 years old and has worked hard all his life. Unfortunately, homemaking was not one of his strong points. The Alzheimer society recognized his need for help and was there to give counsel to those with a more clinical outlook who had assessed him as lazy because he could not keep house and look after my mother as well as he appeared to be able to. The Alzheimer society recognized his cultural upbringing and his inability to change and learn a foreign skill at 78 years old. By utilizing the Red Cross respite homemaking service and the Alzheimer day away program and by showing concern and help to a man willing to change what he could, they were able to keep my mother in her home more comfortably, and with an improved outlook, for two years.

The support group gave my father the release he needed and the understanding that there were others like him. For those who have more natural homemaking tendencies the times are longer, and the wives of men with Alzheimer seem to be able to do even more. This appears to me to be a saving to the long-term care, since maintaining someone in an institution costs considerably more. For this reason, I believe that respite care is essential.

The Alzheimer day away program maintained my mother's skills as long as they could and there was a marked change in her state of mind when she went there. Now in the nursing home, my mother has teamed up with one other lady from the day away program and they seem to have a communication all their own. They are reasonably happy, and this helps those who are caring for them at the nursing home now.

With the Alzheimer day away program and the Red Cross respite homemaking in place, assessment of my mother's condition was easy and the flow of help was quick. With Alzheimer disease, the need for quick response is essential to the safety of the patient and society itself. The need for specialized help is real and the Alzheimer society should remain able to work for these special people.

Ms Lailey: I'd just like to close and ask that the

following recommendations be considered in order to effect positive change for persons with Alzheimer disease and their care givers:

- Easy access to information, and referral to appropriate services;
- Personal reassessments on at least a twice-yearly basis;
- Quick response to requests for respite care;
- Education about Alzheimer disease be available for all care givers;
- Adequate levels of respite homemaking be available to meet the special needs of family care givers;
- Allocation of money from the funding envelope to reflect the number of individuals with Alzheimer disease or some other dementia;
- Inclusion of persons directly affected by Alzheimer disease, and a representative of the Alzheimer society, on the board of directors of the multiservice agency;
- Establishment of a local appeal process;
- Involvement of the local chapter of the Alzheimer society as a part of the total care plan;
- Continuation of the specialized Alzheimer day away program.

In order to respect the time limit set for today's presentations to the committee, our brief has focused primarily on the needs of Alzheimer persons and their family care givers, our greatest concern. However, this in no way diminishes our further concerns regarding the implementation of Bill 173 and the multiservice agency.

We recognize the potential impact on the role of the society, its board of directors and volunteers as well as on our ability to fund-raise in the community. These issues continue to be discussed at length as we attempt to chart our course through these challenging times.

On behalf of persons living and coping with Alzheimer disease, the Alzheimer society board, volunteers and staff, we would like to thank you for this opportunity to share our observations, concerns and recommendations regarding the effective provision of services to Alzheimer persons through the implementation of the multiservice agency.

1520

The Chair: Thank you very much for your submission and also for the appendix with the recommendations. We have time for a question from each caucus.

Mrs Karen Haslam (Perth): Sorry, Mr Chair, I was handing him one of the questions I want him to throw in when he's talking.

The Chair: If he can weave that all into one nice, big question, that would be appreciated by the Chair.

Mr Martin: I just want to, first, thank you for coming forward. It's probably the closest we've come yet to hearing from a consumer group, I think.

Mr O'Connor: We have heard from a few.

Mr Martin: Anyway, it's good to hear from somebody who is directly in contact with and representing a group of people that actually is a very specialized group in this whole area.

I want to say thanks for all the work that you've done and to assure you that this initiative of the government is to try and build on the good work that you do and include the volunteers and the efforts and the donations, the goodwill that you've generated in the community up to this point.

I wanted to ask the parliamentary assistant and perhaps the ministry officials if they would help me share with you more concisely what's in this bill for groups such as yours specifically because it is a specialized area. I think it's addressed but I'd like them to tell you. Perhaps you might want a contact on that.

Also, my colleague here wanted to know, if I might, while I'm at it, throw this in: You suggested that a local appeal process be established for review of any service delivery decision with which a consumer is dissatisfied. She's asking how and who you mean there.

The Chair: Perhaps we could begin with the last question first and then we'll come back.

Mr Martin: Okay, yes.

Ms Lailey: I've read the act, by the way, and my intimation from it is that the appeal process would happen at some larger level, an appeal board. I read into it that it would happen in Toronto or somewhere.

For Alzheimer families that's impossible. They have to be able to say and articulate their needs. In Maria's example, when her father came forward and needed homemaking assistance, he was not assessed as qualifying for the level of assistance that he needed, so they had an avenue open to them to come to the Alzheimer society and access our little pot, as it were.

I think that in this larger picture there has to be a process locally, whether it is a volunteer group, an adjunct to the MSA, a committee here or the board of directors, some kind of an appeal process that people can go to.

The Chair: The parliamentary assistant on the first issue.

Mr Wessenger: I'm going to refer the matter to Mr Quirt particularly for how your society would relate under the bill. But I also understand your concerns about a local appeal process. I would assume that would be part of the planning process to ensure that there is an informal appeal process that could deal with problems, because I agree; in the appeal process, the end result is a very complex and difficult one.

Mr Quirt: The first comment I'd make is that the bill allows for a more flexible approach to meeting the needs of clients in their own homes and does specifically reference support to care givers and respite care in that context. As you well know better than we do, respite for care givers can be provided in a number of ways, whether it's a volunteer, a homemaker, a professional or perhaps a short stay for the person being cared for in a long-term care facility. We hope that all throughout the system respite care will be a bona fide, legitimate reason for providing service. That's been a problem up till now.

With the home care program we had to define somebody as a patient, and whether in fact the family was trying desperately to cope, to maintain that person at

home, was often beside the point. So, by having respite front and centre and support to care givers front and centre we are letting our service providers do what they've wanted to do all along, and that's being more supportive to families like the ones you represent which, by the way, provide, according to Statistics Canada, about 90% of the long-term care in Canada. The publicly funded programs account for about 10% of the long-term care support activity that's done for citizens in the country.

I'd mention a second point with respect to day care programs that are specific to long-term care facility settings. It's been recommended by a number of presenters to the committee that we consider exempting those facility-based programs from the limitations that may be inherent if, for example, the purchase of those services were to go over the 20% limit in the bill. That's certainly something I know our minister would be very interested in getting your viewpoint on and discussing and looking at alternatives there.

The third point I'd make very briefly is that I know that in some communities there are some highly specialized services that your organization provides, and part of the rationale for allowing the 20% purchase limit in three areas was to make sure that those specialized and hard-to-duplicate services could be available through that mechanism. It wouldn't surprise me if that would be the approach that many district health councils would take in their planning.

One further point on the appeal process: There is an appeal process now, but I think your point is well taken that there are all kinds of other steps that need to be gone through, dealing with the agency administration, the agency board and government officials, prior to the client exercising the right to go before the appeal board. An earlier presenter from municipalities talked about the home care program. Well, right now that appeal board could make a ruling binding on that municipal government and its operation of the home care program. It doesn't happen very often because of what you've suggested, that people sensibly get together and try to find resolutions before it gets to that point.

The Chair: Would you like to make just any brief comment on that? Then we need to move on to the next questioner.

Ms Lailey: No, I don't think so.

Mrs Barbara Sullivan: Thank you very much. I think that many of the issues you've raised are ones that have been of some concern to our caucus over the past while. We have heard from one other Alzheimer organization as well as doctors in the public service who have been concerned with the illnesses associated with dementia, including schizophrenia and Alzheimer. We are now working on wording in our caucus to take forward, to include in professional services under the bill a notation that there ought to be services required for persons with dementia. I think that just adding that surround in the bill may be of some help.

I also wanted to respond with respect to your raising the issue of the appeal process. It seems to me that now a person who has Alzheimer or any other long-term

illness that's a mental illness is in a particularly difficult situation with respect to appeals. I think, by example, of the monumental legislative surround that is either in place now or coming into place in a very short period of time with the Advocacy Act, the Consent to Treatment Act, the Substitute Decisions Act, the appeal process with respect to long-term care facility entrance, now another appeal process here, and frankly it doesn't make sense.

1530

A lot of these things are being put into place simply because there is a viewpoint that there isn't a trust, a trusting relationship that exists between a care giver and a patient or a client. I think that, frankly, is a frightening commentary on our society. But, as well, I think we have to come to terms with reality, that when people want to or feel the need to have a decision altered, there has to be a simple and reasonable process as close to home as possible to ensure that will happen. We will be working also on recommendations not just for a vague idea that an MSA might put in its own rules, but for actually something that's included in the legislation, because now the appeal process that's included in the legislation is to the Health Services Appeal Board.

I wanted to ask the ministry if all of the services that you've outlined on page 5 of your brief, including the wandering person registry—some of them we know are included, but the wandering person registry, the volunteer companion program, the in-home activity therapist and the day-away program—are in fact included in the basket of services using other words.

Mr Quirt: I think it's fair to say they're included using other words. The wandering person registry, for example, or the care giver support groups are often funded as a home support program now and it would be included under the community services heading in the bill.

The in-home activity therapist could arguably, I suppose, be considered as a community support or a professional service, depending on the type of therapist that's involved. If it's an occupational therapist or a physiotherapist, that's certainly included as a core service. The day-away program, day care programs are mentioned specifically, and using homemakers for the purposes of respite and care giver support is definitely included.

Mr Jim Wilson: Thank you for your presentation. I found it interesting. Following on Ms Sullivan's question, because I wrote the same or probably similar notation to what she probably made on her page 5, and that is, it seems to me that a number of the services that you're either hoping to deliver—I'm just a little unclear. You talk on page 6 about the \$60,000 budget that, in conjunction with the Canadian Red Cross, you're co-administrating?

Ms Lailey: Yes, it's rather unique. The dollars are funded through the Ministry of Community and Social Services, the long-term care division. The dollars go to the Red Cross and they administer them. One of our staff works with the administrator of the Red Cross program and we are the referral point. None of the programs that are mentioned here receive any funding at all. Our chapter is totally self-supporting through donations and

fundraising. So the dollars that serve that homemaking program go directly to Red Cross for service.

Mr Jim Wilson: That's good to know, because I had written down that unless there was an exemption from the 20% rule, you're toast.

Ms Lailey: I'm not sure it's clear at this point whether that \$60,000—and that's the \$60,000 question. Will it get put into the big pot or will it be left for access by our kind of person?

Mr Jim Wilson: Well, let's ask that because it's key or else you're out of business, for that part anyway.

The Chair: The \$60,000 question then goes to Mr Wessenger.

Mr Wessenger: I'll refer it to Mr Quirt.

Mr Quirt: If in fact what's happening now, and I'm going to have to speculate a bit, is that the home care program, when wishing to provide homemaker services, is particularly sensitive to a family situation with Alzheimer, the Red Cross collaborates with your organization and you make sure that the homemaker is sensitive and trained to meet the needs of that client.

Ms Lailey: That's correct. It helps the Red Cross homemakers that go into Alzheimer homes and make every effort.

Mr Quirt: Yes. I don't see why that type of an arrangement couldn't exist either for the homemakers that are employed by the MSA, or continue to exist, if it was appropriate, to be purchased on a specific basis for those clients. It would only take a \$300,000 homemaking budget, and I'm sure the homemaking budget for both home care programs is about 10 times that, to allow your funding to flow within that 20% rule.

Ms Lailey: Well, we would continue the education piece. I think our concern is the dollars for specific respite care for Alzheimer persons. I don't see where that—

Mr Quirt: I think most people would conclude that it will be easier for the folks in the system now to respond to the homemaker needs of families caring for people with Alzheimer under the new system than it is currently.

Mr Jim Wilson: If you don't have an exemption of 20%, if you're doing the training component and there is a dollar value attached to that and you fall under the 20% rule, you'll have a constant battle, I would think, with the MSA to make sure that you can continue to do that training outside of the MSA because large government bureaucracies, the way this thing's set up, want to do as much in-house as possible. I fear for the—

Interjections.

The Chair: Order, please. It's getting late in the afternoon.

Interjection: No, no. It's a good point, though.

The Chair: I realize it's a good point but all I wanted to say was we are running a bit late and tomorrow morning we are meeting with your counterparts, the Ontario association. Perhaps we'd have an opportunity to continue some of this discussion, but I just regret that we need to move on to our final presentation for today.

Mr Jim Wilson: Can I ask you a question while you're changing presenters, then?

The Chair: On behalf of the members of the committee, thank you for coming before us this afternoon.

I'll just call the next witness and then, Mr Wilson, turn the floor back to you. Representatives from the Ontario Community Support Association, areas 11 and 12, if they would be good enough to come forward.

Mr Jim Wilson: Just a quick question, if Mr Quirt could expand on his comment in response to the previous presenters. When he talked about that the minister may contemplate or be amenable to an exemption from the 20% rule of some facility-based services, that's the first time we've heard that, is it not?

Mrs Barbara Sullivan: No. Point of order, Mr Chairman: Yesterday there was a commitment to an amendment that would ensure that the facility-based adult day programs were exempted from the 20%. There was a firm commitment. I made that note as well and I was surprised to hear today that the worm has turned and now the response is that the minister may consider an exemption.

The Chair: Was this the reference on the questioning yesterday in Hansard?

Mrs Barbara Sullivan: Yes.

Mr Jim Wilson: That's my point. It's a tough one to nail down. So what is the answer?

The Chair: Well, we can also get the—

Mr Jim Wilson: I'm still waiting for the breakdown on the \$850 million. I mean, how many days, Mr Chairman, do you expect us to wait for answers?

The Chair: Briefly then, Mr Wessinger, do you have a comment? I think the other thing we can do is—

Interjections.

The Chair: Order, please.

Mr Wessinger: I think Mr Quirt's position is that he's prepared to recommend the situation. I think that's what he's on record as and, obviously, until the matter comes before the minister no final decision can be made.

1540

ONTARIO COMMUNITY SUPPORT ASSOCIATION,
AREAS 11 AND 12

The Chair: Welcome, our final presenters for today. I want to welcome you. The members are getting a little antsy here, but I can assure you that they're going to—

Interjections.

The Chair: That's right. It's going to be an interesting flight back down south, I suppose. But we welcome you both to the committee, and if you'd be good enough to introduce yourselves to members of the committee for Hansard, then please proceed with your presentation.

Ms Angele Poitras: Good afternoon. My name is Angele Poitras. I'm the director of Meals on Wheels in Sudbury and I'm a member of the Ontario Community Support Association. I'm here representing areas 11 and 12 today.

Beside me is Russel DeCou, assistant to the director of Meals on Wheels, and he will be available to answer

questions as well in the second half of this presentation.

The presentation will begin with a brief overview of what OCSA is and that will be followed by areas of legislation that OCSA endorses and the key areas of concern. Given the time constraints, I hope that you all have received the OCSA response regarding Bill 173. If you have not received that, please inform Mr DeCou and he will make sure that you receive it very shortly.

The Chair: We have copies of that document.

Ms Poitras: Wonderful, Mr Chair. I'm hoping to talk just for 15 minutes; and then 15 minutes for questions and answers or anything else that may occur in the last 15 minutes.

The Ontario Community Support Association is an organization of direct providers of community-based services. The primary purpose is to support, promote and represent the interest of community-based, non-for-profit health and social service agencies across Ontario.

OCSA was created on April 1, 1992, through an amalgamation of three provincial organizations, being Meals on Wheels of Ontario, the Ontario Association of Visiting Homemaking Services and the Ontario Home Support Association. All have long recognized a common interest in supporting community service and all have a long tradition of service in the community program. In fact, 1993 marked the 30th anniversary of Meals on Wheels of Ontario, and 1996 will mark the 25th anniversary of the Sudbury Meals on Wheels program.

OCSA is governed by a board of directors consisting of 25 community leaders. We all have representation from francophone and native communities. All are volunteers. The 300 member agencies across the province service 600,000 clients, have 10,000 dedicated staff and an army of over 45,000 active, hands-on volunteers who work diligently to provide this necessary wide range of services. Many of the volunteers in these programs are seniors themselves.

In 1993 these volunteers donated 1.2 million hours of service. In Sudbury alone, Meals on Wheels program utilizes 300 volunteers to deliver over 30,000 meals yearly to over 400 people. In the Nipissing-Timiskaming area, which is area 11, over 700 volunteers service over 4,000 people.

I'm sure you're aware of the programs that are contained within OCSA, and I'll name just a few: Meals on Wheels, Alzheimer day programs, client intervention and assistance, seniors' day programs, and the list goes on.

OCSA is subdivided into 15 areas. I'm here today to represent areas 11 and 12, which comprise the following: Cochrane, Muskoka, Nipissing, Parry Sound, Timiskaming, Algoma-Manitoulin and Sudbury. One of the great strengths of a provincial organization like the Ontario Community Support Association is the direct, concerted voice that we provide.

The membership supports several aspects of Bill 173, one of them being the purposes of the act. OCSA strongly supports the objectives contained in the purposes of the act. It is a key component of this legislation. In a written submission of which you have been given copies, we have suggested minor revisions.

The bill of rights: We are committed to a service delivery mechanism that is driven by individual consumer needs which responds to the requirements of natural communities and their cultural diversity and that will support the development of equity of service across the province. In areas 11 and 12 we believe this bill of rights to be of utmost importance as the large geographical we cover and the cultural diversity of our client base will be recognized and treated in an equitable manner.

OCSA recognizes and endorses the client's bill of rights as outlined in the legislation. The necessity of the client being informed is an essential component to providing client-centred services.

As some northern communities in areas 11 and 12 do not have all the services required within an MSA, we are concerned over the appeal process and strongly recommend and support the implementation of two types of appeals.

OCSA recommends that there must continue to be options beyond an appeal mechanism for those clients on waiting lists. Without a second appeal, appeals will be very costly, time-consuming and very confusing for the client.

Rules governing approved agencies: OCSA supports alternative MSA models which endorse the principles outlined in the purposes of the act and which are a result of the community planning process. The act must ensure that services are planned, delivered and evaluated from an integrated health and social service perspective. We believe in a long-term care system that stresses the importance of maintaining and promoting health, wellness and early intervention in addressing client needs and that provides flexible service along the continuum of care.

OCSA applauds the government for including the provision of the proposed changes to the Public Vehicles Act.

Now we're past the glory and we're on to a few areas of concern that OCSA would like to address. These are based on input from member agencies.

The six areas that are covered are (a) areas not covered in the legislation; (b) the regulations; (c) volunteerism in the reformed long-term care system; (d) multiservice agencies; (e) categories of service; and (f) definitions. The areas I will concentrate on today are the areas that aren't covered in the legislation, in particular the protection of workers, the role of volunteers and the 20-80 split.

In the document *Partnerships in Long-Term Care: Guidelines for the Establishment of Multi-Service Agencies*, released in September 1993, messages regarding the perceived preferential treatment of unionized employees in the new MSA became apparent. Subsequently in Bill 173 there were no references regarding the protection of not-for-profit, community-based employees as a result of implementation of long-term care reform.

Long-term care reform acknowledges the need for experienced, trained staff for the provision of services, yet the proposed process for the development of multi-service agencies along with social contract reductions and constrained finances all currently have or will potentially

have a negative impact on employment in the broader socio-healthcare sector.

Also, a forgotten group of employees are those who work through brokerage agencies, and they should have their experience recognized in this process. The community support sector consists of 10,000 employees who are experienced and trained in the care and delivery of services. These staff have worked for years for low wages and minimal benefits, their only benefit being their client. They have a strong commitment and loyalty to providing quality services. Unionized employees in the broader socio-healthcare sector are demanding priority employment in the community sector. Our sector is predominantly non-unionized and thus less able to voice concerns.

OCSA recommends that client continuity and respect of the relationship between existing employees and consumers of service should be paramount. Consequently, employee transfers to new agencies should be seamless with no break in employment or client service.

All employees of not-for-profit community support service agencies should be guaranteed comparable positions in the new service delivery structures without loss of seniority. Otherwise, in all community support sector hiring, displaced employees from not-for-profit community support agencies should be given priority over other socio-healthcare sector employees.

To reiterate the concerns of Mark Mieto earlier from the region of Sudbury, I will speak only for areas 11 and 12. I think that the actual job titles must be really looked at. Job titles are not truly indicative of the job descriptions that people are performing. As mentioned previously, an executive director in an agency may be answering the telephone and taking client applications and delivering meals in that sort of instance where there aren't a lot of staff. There aren't personnel managers, there are no finance managers.

To give further credence to that, just last week I had to go pick up a burnt meal and discuss it with the client and then bring it to the food source, and I am listed as an executive director of a Meals on Wheels agency. So I think we have to seriously look at what actual job duties are within a particular job description.

With the job description being looked at, there is a possibility that once job descriptions are looked at, not just job titles, it may require two people to perform one job, and will this really be truly cost-effective with the new system?

The staff that are currently managing and doing the day-to-day operations of these agencies are trained and they're willing to undergo more training. They have relationships with clients, community contacts, and are dedicated to their clients and their mother agencies, and they deserve to be a top priority.

Pages 35 to 41 deal with the general regulations, and it is a view that Bill 173 has taken an overly prescriptive approach to the provision of community-based services. OCSA is concerned that 42 regulations have yet to be produced. Much is unknown at this time, yet the areas to be covered appear to be quite prescriptive. It is very difficult to present a response to the legislation in the

absence of the detailed information which will be in the regulations.

OCSA recommends that OCSA must be actively involved in producing and approving the regulations to be developed for Bill 173. Furthermore, OCSA recommends that extreme caution needs to be applied in setting retroactive dates of application.

The next issue I'd like to address is volunteerism in the reform long-term care system. It is an essential component in the delivery of community-based services. Many could not function without it. The volunteer base must be recognized as being deeply rooted in the community and potentially fragile. In addition to their work in direct service provision, they also raise a significant amount of dollars that allow programs to continue.

1550

There is a lack of detailed planning regarding volunteers in the long-term care. Historically, volunteers have always been the backbone of community support, and they must be recognized and the issue addressed. OCSA recommends the following: that there be recognition of the role of volunteers in the body of the legislation, and that volunteer management in regulation number 11 should be expanded to require MSAs to develop and implement a plan for the recruitment, training, scheduling, supervision, retention, recognition and expense reimbursement of volunteers. The lack of mention in the bill regarding volunteers and the government's viewpoint that the volunteer will continue on in much the same way as before are perhaps an oversight.

Participation in discussions with persons who are volunteers has strongly suggested that your average volunteer will not volunteer for a large bureaucratic organization. Their loyalty is to individual agencies, staff and clients. Volunteer management must be mentioned and given adequate dollars, especially initially when the volunteer base of Ontario will need to be re-educated regarding the redirection of long-term care.

Interruption.

Ms Poitras: Sorry.

The Chair: We're awake.

Ms Poitras: Is he awake too now?

Interjections.

Ms Poitras: Is he? He's leaving? Well, it's 10 to 4. I had to do something to make sure you're all paying attention.

With regard to the volunteerism issue, we have also have to look at the board of directors that is currently in place, the wealth of information they bring with them, contacts. Often you have lawyers or accountants who bring expertise without cost to agencies. Will they be prepared to do this for an MSA or will these services now have to be purchased?

On the multiservice agencies, the only thing I'm going to say about pages 12 and 13 is that it is essential that there be sufficient flexibility to allow communities to develop an MSA system to meet local needs. I think from the presentations I've seen this afternoon that's come out as a very, very strong point. If you've seen the OCSA

response to Bill 173, you've read the recommendations, and it's very similar. Everyone is looking for community input.

The other thing I would like to address is the limits on services purchased regarding the 80-20. It is assumed that the client who has financial resources and prefers to purchase services from a not-for-profit or profit agency will not be restricted. Will there be flexibility allowed over the 20%? What if a client lives in an area where the only available services have to be purchased? There are a number of agencies, some of which are Meals on Wheels, which do not receive any government funding. What will be the impact of this policy on those agencies?

A single provider—for example, a homemaker agency—may provide services that fall within at least two of the service categories. Therefore, it may be very difficult to allocate costs. Will moneys be allocated from the funding envelope to ensure that needed services are developed within the MSA? Will this cause duplication and force other agencies to either (a) become part of an MSA or (b) dissolve because MSA cannot purchase their services?

The 20-80 split of services: Where are these figures arrived at? Are they arrived at by looking at the agencies that will be legislated into being an MSA, and the government has said, "Oh, we will only have to purchase 20% out of the MSA"?

In conclusion, I would like to state that OCSA applauds the leadership demonstrated by the provincial government through the development of Bill 173. It establishes a key building block in the foundation of the new long-term care system. We appreciate the commitment to building partnerships with the community to effectively plan and implement meaningful change.

I thank you for this opportunity to bring forth our concerns and I now leave the floor open to questions and answers.

The Chair: Again, I ask members to be brief in their questions as we do have a bit of a problem with time. We'll start with Mr Malkowski.

Mr Malkowski: Thank you for your presentation. From time to time I volunteer for East York Meals on Wheels. I find that a very valuable service, and I encourage other members to participate in their local Meals on Wheels because I think it's a good experience.

The people at the East York Meals on Wheels spoke to me similarly on points that you mentioned when they talked about the concerns of their non-union members and about other concerns that they heard. A point that they made: They thought perhaps if there was an amendment to the legislation which included a coordinator, a mandated position of coordinator of volunteer services for each MSA, so that they would be responsible for doing recruitment and outreach and training of the volunteers. I would be interested in your comments, if you thought that was a worthwhile idea.

Ms Poitras: Excuse me. Is there one manager of volunteer services for each MSA?

Mr Malkowski: Yes.

Ms Poitras: I will speak on behalf of what I know,

Meals on Wheels, and we'll use that as a basis. We have a volunteer base of almost 400, so if you take just Meals on Wheels—we're not talking VON, Red Cross, Alzheimer's, anybody else who may be part of the MSA—I have trouble in thinking that one person could manage, recruit and train enough volunteers to man every single agency.

Mr Malkowski: Then perhaps do you have any suggestions or other ideas that might help the MSA with this?

Ms Poitras: I think traditionally the position of volunteer management has always been kind of: "Well, if we have the money, we'll hire them. If not, we'll get a volunteer to recruit some more." I think we have to recognize that volunteer managers are true professionals and that the service they provide for the agency is invaluable. They have interpersonal skills that are just unsurpassable, to get these people to do what's needed to be done. So I think that each particular program or department or agency within an MSA must retain its own volunteer manager.

Could I just ask for a clarification from the policy person to reply to that?

Mr Quirt: The presenters were quite right that a great number of our home support agencies have volunteer coordinators, and in effect our funding goes to help coordinate volunteer effort in many home support organizations. So MSAs would be free to have either one large volunteer recruitment training and support department or to have volunteer recruitment people specific to each program, whichever they felt was the best way to do it. But clearly the recruitment and training and support of volunteers is going to be a very necessary, ongoing skill, and that's why it's important that the people who are good at it now continue to do that job.

Mrs Barbara Sullivan: We see the Ontario association recommendations, and I was a little disappointed that you moved so quickly over your reactions to the multiservice agency, because indeed we had a little dispute this morning with respect to what the position of your association was.

I indicated that it was my understanding, from presentations that have been made to the committee, that in fact you had made very strong recommendations with respect to the MSA. Indeed, I have the Ontario recommendations and they suggest, in part, that functional integration of information could be achieved through electronic communication systems, by combining physical locations for smaller community support agencies to achieve economy of finances and volunteers, and that functional integration, of course, would respect the need for increased coordination of access.

Indeed, what you suggest is that "if functional integration is pursued, top priority must be given to ensuring that there is an effective computerized information network in place" etc. You also believe, and I just want to say this for the record and you state quite clearly, that "MSAs must not be allowed to develop into large bureaucratic organizations," which is a very grave concern to all of us. You also believe that there must be consistent standards throughout the province.

I also want to note: "One-stop or single-access does not necessarily mean that all services and care providers have to be assembled under one roof and that consumers have only one point of contact in the community." It may, for example, be achieved by a functional integration of information, referral, assessment case management, service delivery and follow-up in multiple locations.

Recommendations that you have made through your Ontario body, through the presentation which was made from I think districts 13 and 14 yesterday—and yours today, indicate that indeed your association is not 100% committed to the model which is included in Bill 173, and I want the record firmly corrected.

1600

The Chair: Do you want to comment on that?

Ms Poitras: I appreciate Ms Sullivan's disappointment that I skipped over that. Unfortunately, I wasn't here to actually see what went on this morning, but I figured somebody would bring it up during the Q and A period.

I do have in front of me the policy resolution that was passed by the general membership in May 1994 by OCSA. Their position clearly states: "We believe that community development principles and processes should be applied at the local level in order to develop the appropriate community multiservice delivery mechanisms. Therefore, be it resolved that OCSA support the reform of the long-term care systems provided the following policies are adhered to."

Mr Russel DeCoo: And then it goes into the recommendations.

The Chair: And what you have read, just so we understand, is in the submission.

Ms Poitras: Yes. Like Ms Sullivan has stated, there are concerns. We approve a system that's going to provide better client service, going to be more cost-effective, provide training, adequate staffing dollars, adequate volunteer dollars, but we do have serious concerns that need to be addressed, and that's why seven representative OCSAs will be meeting and talking to your committee.

Mr Jim Wilson: I think in the list of concerns that you did mention today and mentioned in the past, one which is key to this bill is the 80-20 rule, and you mentioned your concerns about that again today. I have a very simple question. Not wanting to be provocative as a Health critic, and doing my job as such, I'll simply ask you, and it's come up consistently in the OCSA briefs and I must admit it's a point that needs a bit of explanation for me: You said today you asked the government to exercise extreme caution in establishing retroactive dates. It's in the list, one of the recommendations.

Ms Poitras: Recommendations of OCSA in their response?

Mr Jim Wilson: Yes.

Ms Poitras: What is it that you—

Mr Jim Wilson: The first four or five times I heard it, I didn't quite know what it meant. What does it mean? I know there are some retroactive dates in terms of an

MSA taking on its role. There's a one-day overlap or something.

Ms Poitras: I think it all has to go along with the former presentations that you've had today, just extreme caution in everything: the go-ahead dates, that sort of thing. OCSA just wants to make a stand that they would like things to be clearly thought out before things actually go ahead, and have ramifications of retroactive dates fully been thought out? That's my understanding.

Mr Jim Wilson: Is it referring to a clause in the bill, Mr Quirt, do you think, or the parliamentary assistant?

Mr Wessenger: I'm advised that there is a power in the bill with respect to making retroactive regulations, or regulations retroactive. I'm also advised it would be exercised with due caution because it generally relates to the question of funding issues, to recognize the fact that moneys have been advanced in the past. So that's the purpose of the regulation, as I understand it.

The Chair: Thank you for coming before the committee this afternoon. Before adjourning our meeting here, I think it only appropriate to ask Mr Martin if he wishes to make a few brief closing remarks.

Mr Martin: Can I finish the discussion with Ms Sullivan?

The Chair: Oh, no. I would prefer we did some nice things about Sault Ste Marie and the district of Algoma so that we can leave in a cheery mood.

Mr Martin: I just want to thank the committee and all who are involved for coming to the Sault and hearing us out here. I think today as well, to the folks who have been here, the committee has heard a very full and fair representation of the level of concern and interest, and actually enthusiasm, about this whole process, and I think it will only but be helpful. So just thank you to everybody. It gives a face to the democratic process that we often so much talk about and yet don't always see, so thanks very much.

The Chair: Thank you, Mr Martin. To the committee members, the bus for the airport will be at the front of the hotel in about 25 minutes, at 4:30, so if people could make sure they are there and we'll go out to the airport. I would remind everyone that we begin our hearings again tomorrow morning in Toronto at 9:30 and then later in the afternoon go on to London, where we will be meeting tomorrow evening.

With that, the committee then stands adjourned until tomorrow morning at 9:30 at Queen's Park.

The committee adjourned at 1606.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

- ***Chair / Président:** Beer, Charles (York-Mackenzie L)
- ***Acting Chair / Présidente suppléante:** McGuinty, Dalton (Ottawa South/-Sud L)
- Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
- Carter, Jenny (Peterborough ND)
- Cunningham, Dianne (London North/-Nord PC)
- Hope, Randy R. (Chatham-Kent ND)
- *Martin, Tony (Sault Ste Marie ND)
- *O'Connor, Larry (Durham-York ND)
- *O'Neill, Yvonne (Ottawa-Rideau L)
- Owens, Stephen (Scarborough Centre ND)
- *Rizzo, Tony (Oakwood ND)
- *Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Haslam, Karen (Perth ND) for Ms Carter
Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham
Malkowski, Gary (York East/-Est ND) for Mr Hope
Sullivan, Barbara (Halton Centre L) for Mr Eddy
Wessenger, Paul (Simcoe Centre ND) for Mr Owens

Also taking part / Autres participants et participantes:

Ministry of Health:
Czukur, Gail, legal counsel, long-term care legislation
Quirt, Geoff, acting executive director, long-term care division
Wessenger, Paul, parliamentary assistant to the minister

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Gardner, Dr Bob, assistant director, Legislative Research Service

CONTENTS

Tuesday 23 August 1994

Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,	
projet de loi 173, <i>M^{me} Grier</i>	S-1873
Canadian Red Cross Society, Ontario division, Sault Ste Marie branch	S-1873
Shelley McEachern, chair, homemaker services committee	
Sue Irvine, member, Timmins and district homemaker services committee	
Ontario March of Dimes, Sault Ste Marie regional office	S-1877
Valerie Scarfone, independent living manager	
Sault Ste Marie General and Plummer Memorial public hospitals	S-1880
Manu Malkani, president and chief executive officer	
Johanne Messier-Mann, manager, long-term services, palliative care and psychogeriatrics	
Laurie Walton, director, ambulatory and community services	
Victorian Order of Nurses, Algoma and Sudbury branches	S-1884
Sharon Baiden, executive director, Sudbury branch	
Cheryl Sullivan, assistant executive director, Algoma branch	
Charlene Brown, nurse manager, Espanola suboffice	
Algoma District Health Council	S-1891
Jim Dalgliesh, chair, long-term care committee	
Susan Van Atte, health care planner, long-term care committee	
Porcupine Health Unit	S-1894
Dr John MacIntyre, acting medical officer of health	
Joan Cameron, director, home care program	
Regional Municipality of Sudbury, health and social services committee	S-1899
Jim Griffin, member, health and social services committee	
Mark Mieto, director, health and social services, Sudbury region	
Algoma Health Unit	S-1902
Gail Russell, administrator, Algoma home care program	
Dr Allan Northan, medical officer of health, Algoma	
Alzheimer Society of Sault Ste Marie and Algoma District	S-1907
Brenda Lailey, chapter administrator	
Maria Bell, member and care giver	
Ontario Community Support Association, areas 11 and 12	S-1912
Angele Poitras, representative	
Russel DeCou, representative	



S-64

S-64

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Wednesday 24 August 1994

Journal des débats (Hansard)

Mercredi 24 août 1994

Standing committee on social development

Long-Term Care Act, 1994

Comité permanent des affaires sociales

Loi de 1994 sur les soins
de longue durée



Chair: Charles Beer
Clerk: Doug Arnott

Président : Charles Beer
Greffier : Doug Arnott

50th anniversary

1944–1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Wednesday 24 August 1994

Mercredi 24 août 1994

The committee met at 0937 in committee room 1.

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. Welcome to the standing committee on social development. If committee members look a little jet-lagged, it's because we've been in Thunder Bay and Sault Ste Marie and other places the last couple of days. But we're glad to be back in Toronto this morning, and then we're off to London for tonight and tomorrow as we continue with our hearings on long-term care.

ASSOCIATION OF LOCAL
OFFICIAL HEALTH AGENCIES

The Chair: Our first witnesses this morning are from the Association of Local Official Health Agencies. Introduce yourselves to the members and for Hansard.

Mr Richard Cantin: My name is Richard Cantin. I'm president of the Association of Local Official Health Agencies, and with me is the past president and the medical officer of health for the region of York, Dr Helena Jaczek; Alex Lampropoulos from the Kingston board of health; and Gordon White, our executive director.

As many of you know from past presentations, the Association of Local Official Health Agencies is the collective voice of and the provincial umbrella organization for the 42 boards of health of Ontario.

Throughout its evolution, ALOHA has remained committed to the purpose of providing a base for program assistance, consensual representation, political advocacy on behalf of boards of health and their communities, and continuing education.

Even before the inception of long-term care programs such as home care and placement coordination, Ontario's public health units were in the forefront of community-based management and programming. However, the present Long-Term Care Act appears to preclude some actions that will better meet the objectives that ALOHA has had over the years which were, we feel, well carried out over the years, and it risks increasing bureaucracy and reducing direct services, relative to available funding.

The goals of our presentation this morning are, first, to convince this committee that boards of health should be considered on an equal basis with other community groups to become the multiservice agencies and, second, to establish justification for piloting multiservice agencies

in a few locations before committing the whole province to an untried model. We suggest one rural and one urban site for pilots.

Dr Helena Jaczek: As communities have evolved over the past century, we also believe that so have boards of health. We've had boards of health in this province since the 1830s, and we feel that through the years we've shown continuing responsiveness to our communities.

For the most part, members of boards of health have been elected representatives from their communities. They have been responsible and accountable to those communities in their roles on boards of health.

We feel that this flexibility and adaptation is clearly shown by in fact the wide variety of programs that you will find in any particular individual health unit. What can seem at times to be a somewhat fragmented and puzzling array of services actually, in our view, shows that we have responded well through the years to the needs of our communities. In fact, you may find such a variety of programs funded by a multiple of different sources that sometimes it's hard to see a connection. You'll see services such as community-based mental health, infant development, placement coordination, environmental health and, of course, home care.

As probably most of you are aware, in the mid-1970s it was to boards of health that the province turned to implement home care programs in a very large part across the province in fact, so that now we have 29 of the home care programs administered by boards of health in this province. That is in fact over 75%.

While we acknowledge the government's efforts to produce very much needed change in the area of service delivery in the long-term care arena, we do not see that this need for a change and adaptation to consumer needs in the service area necessarily must lead to a change in governance and management.

In other words, we do acknowledge, and I think many boards of health have shown that they have acknowledged, the desires of consumers for easier access to the system. In my own health unit in York region, we're looking at a 1-800 number for access to multiple community and support services. This initiative was produced through what we call the community agencies in partnership network, eight agencies working together, coming to a decision that there was a need for a centralized 1-800 access number, and we hope to put this in place this fall. There are many other examples of such partnerships with other community agencies across the province.

Mr Cantin: In fact in Ottawa-Carleton, one of the

things we did a few years ago was to institute an appeals process in the home care program, and there are more community representatives than there are board of health representatives. I happen to be the only one on that appeal board. The other two are community representatives from agencies representing either old age security recipients or people with special needs.

We also instituted a granting program from the board of health. Again, there's only one representative from the board of health and seven from the community, so we do have a lot of community participation in our programs. Those are just examples.

Where boards of health have had control over their own budgets and over the administration of budgets, they've been noted for their fiscal responsibility. Boards of health have provided high-quality services and met budget limitations resourcefully. They've continued to demonstrate an ability to prioritize and adapt services to meet community needs.

While ministry budgets have included the service of case management as administrative costs in the past, actual conventional administration costs of programs such as home care are less than 10%. Thus, by allying with other services in health units, more dollars are available for direct programs.

Not only do health units have the expertise related to managing a large organization, they're actively involved and responsive to communities. They are also one of the few organizations found across the province which requires their CEO to have at least master's level training in public administration, and I say this being an individual who doesn't have a degree. I feel this is important, to have somebody who's got some competence in this field. Many of the medical officers of health have fellowship certification by the College of Physicians and Surgeons as well.

Dr Jaczek: One of the major assets that the health units can bring is a strong evaluation component to any particular program that we run. We look at the epidemiological underpinnings of causation of disease in our communities and obviously we try and design programs to lessen the risk of disease; in fact, to allow people to live at their optimal state of health. We think this is extremely important, even when you're looking at what is classically viewed as a treatment program such as home care.

The consultation that this government did pursue revealed that many, many seniors, many of the people who came out to those consultations wanted a wellness focus. They wanted that the long-term care reform process ensure that there be a health promotion aspect to the program. We feel that this is what we can offer.

The core of our business in public health of course is in fact health promotion, though we offer so many other different programs. But that is what we truly believe, that with broad population-based programs we will see a shift in individuals' health. Health care is the last resort. We bring that perspective to the home care program as well.

A number of health units are in fact teaching health units, some eight of them across the province, again in

terms of evaluation and research into the best possible, most cost-effective and service-oriented, resulting in consumer satisfaction types of programs. We feel we have all that to offer as well.

In essence, the nature and tradition of boards of health have showed that they've played a key role in communities, making the bridge between the clinical and community. Boards of health understand population health. They know that it goes beyond the individual, but it does not neglect the needs of the community. It brings understanding from a broad range of perspectives to the solution of community problems in a facilitative way.

Mr Cantin: All but a few of the home care programs in Ontario are currently based in health units; as we've already mentioned, about 75%. Most of the integrated homemaking and placement coordination services, as well as other long-term-care-related community programs, are administered by health units. It is this which forms a logical base upon which to build multiservice agencies of the future, rather than attempting to start over with unforeseen problems. The logistics of starting over with whole new organizations, as opposed to building upon what exists, are staggering.

Profound, untested change is rarely in the best interests of the consumer. Radical restructuring and its inherent focus on systems and administration inevitably will detract from patient services and the ability of the organization to be responsive to its board and community. Issues that will consume the time of totally new organizations for many years to come will include development of new structures; staffing, including trying to decide which unions represent what; policies and procedures; renegotiating of union contracts; office leases; organizational and legislative requirements, and the list goes on. In fact, try imagining creating an organization with a budget of \$100 million to \$150 million overnight. It ain't gonna happen, not without an awful lot of hitches.

The point we're trying to make here too is that representatives of government, be they elected or staff, have consistently stated that health units have done excellent work with the difficult job of implementing programs like home care. Without compelling reasons to the contrary, it's unfortunate that boards of health, which are most able, with relative ease, to move into a program-delivery phase of the MSA, are specifically identified as being considered only after all other options have been exhausted. Proponents of long-term care reform have always placed emphasis on community choice in governance and delivery of service. Subsection 11(3) effectively eliminates the logical choice of the board of health. If the goal is improved service, this cannot be achieved by micromanagement from Queen's Park, and that's what's going to happen.

In summary, the boards of health bring a broad range of experience and expertise to the administration of community-based programming. Their mandate under the Health Protection and Promotion Act is to ensure the effective provision of a range of services to the community. They provide a fundamental and community-based health promotion focus in all their programs. In times of difficult financing—and we've lived with that in the last

few years—and increased public expectations, there is a strong case to be made for building on strengths rather than trying to start organizations from scratch.

In this context, boards of health should be considered for the development of the future MSAs and legislation should be changed to encourage this. This can be accomplished incrementally, with immediate progress, without the need for either new legislation or attendant costs of creating new structures. Thus, subsection 11(3) should be deleted. We also urge that the new governance model be piloted in one urban and one rural milieu prior to full implementation.

Thank you for your time.

0950

The Chair: Thanks very much. We'll go right to questions, beginning with Mr O'Connor.

Mr Larry O'Connor (Durham-York): Thank you, Mr Chair. I appreciate that.

First of all, I want to thank you for allowing me the opportunity to address your body back at the conference. I appreciate that. We have heard from health units, and I know that in your deliberations you mentioned health promotion. You've got a lot of work ahead of you with the tobacco legislation, which did receive third reading and—

Mr Cantin: We're happy about that.

Mr O'Connor: —hopefully will be proclaimed in the near future.

York East actually put together a little brochure that they shared with the committee in dealing with the needs. East York public health unit didn't want to be one of the bodies to deliver or to be the MSA, but still they recognized the needs of seniors.

It's interesting the number that you gave, \$150 million for a budget and finding an entity to deliver that service. I think the total for Metro home care alone is around \$100 million, and that's going to be divided up. It's not going to be left with one MSA. So it's not the sense that there's going to be all of a sudden somebody out there who's given \$100 million or \$150 million: "Here's your budget. Go out there and manage it. Go out there and be an MSA." That's not the intention. The intention is to really see the community involved and see some partnership within the community.

We've seen a lot of partnershiping. York region's a good example for partnering when we've seen the palliative care proposal come forward, and funding from the government. Again, the quick response. There's some really good partnering that has taken place.

One thing that has been pointed out to us has been the volunteers. As a public health unit, I guess you people are going to say, "Well, that's a government body." People are telling us that an MSA—and we don't want to be the people in charge of the MSA. We want to allow the community to develop it and evolve it, so we don't feel that it's going to be government-led, something from Queen's Park saying, "This is how you're going to run it all," that approach, other than telling them, "This is the minimum basket of services we expect you to deliver."

How would a public health unit then bring in that volunteer element? We're hearing it repeatedly told to us that people won't volunteer for government.

Mr Cantin: In fact, that volunteer element already exists, and I will point out to you, when Ottawa-Carleton had the meningococcal disease scare two years ago, more than half of the people involved in the inoculations were volunteers from as far away as Kingston. So it's in existence. In many health units, including Alex's in Kingston, he's got an army of volunteers and it's not unusual to see that happen.

Whether it's programs like Meals on Wheels or whatever program is offered in the community, there is a distinct fear that if there is a body which formalizes all the services that are there, there may be a loss to the community by people who say, "Well, now I'm working for the government, so I should get paid for it," whereas there's a loss of that community spirit in what's happening currently. That's been our perception in our area, but we do have a lot of volunteers currently working for something which is locally directed, if you want.

The elected representatives, much like you, get their marching orders from their electorate and they're much more receptive to the overall needs of the community than a representative from the Red Cross might be, for instance. I could see the scenario because it happens in municipalities sometimes when you try to get roads. I can see Red Cross telling United Way, "Well, if you support me on this, I'll support you on that." Then the whole public need gives way to maybe special needs and I'm not sure this would be the effective use of the dollars. I don't know if anybody else has—Dr Jaczek?

Dr Jaczek: I think what we're recognizing here is that there should be the role of the community decision-making process to proceed. We're just saying we would like to see subsection 11(3) deleted. I think there is a potential for a variety of models in communities. Obviously we're aware in the north. Apparently many home care programs do in fact do direct-service delivery. That's the way they operate because that's the need of that community.

In more urban areas where you have a multiplicity of volunteer agencies, not-for-profit agencies, we would like to see the potential for the community through the DHC process to make a decision as to what makes sense for that community: How much are you going to amalgamate? Or how little are you going to amalgamate? And we would like to see that process continue, allowing obviously where there's a huge volunteer commitment to a particular organization that this voice be heard.

The Chair: I'm afraid I'm going to have to move on just because of time.

Mr Dalton McGuinty (Ottawa South): Thank you very much for your presentation. Richard, a special welcome to you back here at Queen's Park. I'll take the opportunity as well to congratulate you on your ongoing good works in Ottawa-Carleton in respect to promoting health there.

I enjoyed your brief. I think it's very good and it outlines for us the valuable role our boards of health have

played in the history of this province in the development and promotion of health care. I recently wrote Richard Schabas, our chief medical officer of health, and I asked him how much of our illness or disease is preventable. He wrote me back and I was astounded. He said that fully 70% of the disease we are treating in this province is preventable.

When you think of the fact that we're spending about \$18 billion on health care in this province, it consumes a little over one third of our budget. If we didn't have enough reason before to promote health in this province, to do all we can to prevent disease, surely for economic reasons we have another compelling reason to do so.

I'm going to direct my question to the parliamentary assistant: What is it that we are doing through Bill 173 that will ensure we promote health, that we consider health prevention as a vital component of this revamping of long-term care in the province and what are we doing to capitalize on the existing expertise that's found in our boards of health?

Mr Paul Wessinger (Simcoe Centre): That's a very good question of how this reform fits in with respect to the whole question of health promotion and I think it's based obviously on one premise. First of all, wellness is a very important part of the whole question of long-term care. I think it's important that there be the component of keeping people who are already healthy, seniors for instance, in the community through the senior citizens programs and so forth. I think they're very much an important part.

The other aspect, particularly with respect to the delivery of care—I think there's a premise that people who are more independent in their lifestyle tend to be healthier. By keeping people in the community longer, I think the impact of that, provided you provide the support services so they can continue to live independently, will keep them healthier in the long run than putting them in institutional care.

1000

Mr McGuinty: I know you responded to this before, but for the benefit of our witnesses I want to ask this again and allow them an opportunity to respond. What is the policy reason behind the bias against local boards of health serving as MSAs?

Mr Wessinger: There have been concerns raised, first of all, with respect to the question of governance in the sense of how do you ensure a board of health would have a board that represented not only consumers, but also represented people with experience in the health field and also people with experience in the social service field. There's a concern about that aspect.

Secondly, there is some concern about the fact that most boards of health are not charitable corporations and that they would be perceived as a government body as distinct from being perceived as a non-profit or charitable body. I think it's fair to say that there's a concern that perhaps that might have an impact on donations. We'll be hearing later from the United Way, and it will be interesting to ask them that question too, how they would perceive the aspect of making contributions.

Mr McGuinty: I would just like to allow our witnesses an opportunity to respond to that.

Mr Cantin: It's interesting to note that in Ontario only 2% of the health budget goes to promotion of health. When the deputy minister first came to ALOHA back in January, we pointed this out to her. We said: "You know, if you doubled that amount, can you imagine what kind of inroads you'd have on the other part of your health budget, and if you tripled, can you imagine? You might even bring down your health budget to maybe half of what it is today." That's the one point: There's not enough on prevention, and there's too much on trying to solve the problem after it's there.

In terms of governance, who better to represent the community, whether it be special needs or the people who are actually funding the programs, than people who are elected by the population at large? You've got organizations where the best people refuse to serve because they don't have the time. Here you've got bodies where people take the time, have interest, they have no choice but to listen to what people have to say because, as you know, we've got elections this year again, as you face every four or five years. The responsiveness of the politicians around the table or the people that you appoint with consultation with the local authorities—they are very much responsive.

Some do come from medical backgrounds. On my board of health, for example, I've got two former nurses, I've got two former social workers, I've got planners. I've got people from all walks of life. You don't have to go to a special-interest organization to find those resources; they are in the community. I think they're a better reflection of what's out there in the community.

The Chair: I'm afraid we have to move on. Mr Jackson, the final question.

Mr Cameron Jackson (Burlington South): I was a little shocked to hear that the notion of the perception that this is going to be a government agency, the MSA, is a reason to limit your access to eligibility to it. I was just flipping through the AMO brief because I assumed—correctly, upon reflection—that they fully support your position and they will be reinforcing virtually everything you've said.

Mr Cantin: That's without consultation with us, by the way.

Mr Jackson: But good logic is good logic. It bears the test of what's perceived to be right or wrong; it, quite frankly, comes to the forefront.

I guess my frustration is that about five or six years ago the review of social services and municipal relationships was examined by the Ron Book commission. I know that boards of health were examined, along with a whole host of services which are included in the basket of services of an MSA. That report has since died; it's just absolutely disappeared off the face of the earth. But contained within it was a strengthening of this municipal partnership and local decision-making etc.

I guess my question is a pretty obvious one, and you've already responded to it. If ultimately the MSA is going to follow more of a medical model, which we're

told it will, it will be a bureaucratic, government-based service, which is what we're being told by everybody. Why, then, should you not be included? If it walks like a duck and it talks like a duck, why shouldn't you be allowed to be a duck too?

Mr Cantin: I guess the short answer to that is we don't understand it either. But the main thing is that most boards of health have shifted to a business approach to running public health in Ontario. We realize there is a bottom line and you've got to meet it, otherwise the whole system collapses. That's one of the fears we have if public boards of health are not allowed to be MSAs; we'll lose track of that and I can only point out to you what happened with the day care system in Ontario now that the not-for-profit bent has caused an awful lot of people to drop their 80 hours a week as owners of a day care centre to becoming the bureaucratic 40 hours a week, no longer carrying a pager. If you've got a plugged toilet, you call a plumber; you don't get a plunger.

The Chair: Thank you very much for coming before the committee this morning. We appreciate it.

ALZHEIMER ASSOCIATION OF ONTARIO

The Chair: I call on our next witnesses, from the Alzheimer Association of Ontario. Committee members have a copy of their brief. Welcome to the committee.

Ms Angela Morris: Good morning. I am Angela Morris, the immediate past president of the Alzheimer Association of Ontario and the association's public policy committee chairman.

Each of us presenting to you this morning has a long experience as family care givers of relatives with Alzheimer's disease. My colleague, Bernard Leech, is president of the Alzheimer Society of Peel and a member of the AAO public policy committee. Susan Kitchener is the manager of the association's public policy.

With your permission we propose to proceed as follows: First we will review our brief with you and then we would be pleased to answer any questions the committee members might have.

People directly affected by Alzheimer's disease constitute the second-largest group of consumers of long-term care services. How well their needs are met will be a fundamental measure of the success or failure of the reform of long-term care.

The Alzheimer Association of Ontario appreciates the opportunity to present its comments on Bill 173, An Act respecting Long-Term Care, to the standing committee on social development. The measures detailed in the bill will have serious repercussions for people with Alzheimer disease and their family care givers. We believe the comments offered in this paper will, if accepted, help ensure that this large group of consumers of long-term care services will be better served by the programs developed by the long-term care planners across the province.

More urgently, it is our view that if some of the amendments we recommend are not adopted, people with Alzheimer disease and related dementias and their family care givers will be put in danger as we move from one system to another.

Because of the magnitude of the issue, in this presenta-

tion we will comment only on those parts of the legislation that we believe essential to be amended.

Bill 173 focuses on the community side of long-term care and particularly on multiservice agencies. The recommendations we make are, because of this, centred on the community-side aspects of long-term care.

What is the Alzheimer Association of Ontario and what does it do? The Alzheimer Association of Ontario is a non-profit charitable corporation representing 38 chapters throughout Ontario. Together, Alzheimer chapters have a membership in excess of 6,000 people, most of whom have or have had family members with Alzheimer disease.

The association and its chapters have an operating budget of approximately \$7.5 million, with about 27% of the amount currently coming from the provincial government for the delivery of day programs, respite programs and counselling services. As well, chapters operate family support groups, education programs and information services for health care professionals, families and the general public. Many of our community programs are delivered by volunteers who have themselves direct experience with the effects of Alzheimer's disease.

As part of its ongoing dedication to unlocking the secrets of this dreadful disease, the Alzheimer Association of Ontario provides major ongoing financial support to Alzheimer research at the University of Toronto's Centre for Research in Neurodegenerative Diseases. In addition, substantial ongoing funding is granted to studies of the psychosocial aspects of the care of people with Alzheimer disease.

1010

The Alzheimer association and long-term care: Because long-term care is an issue of such critical importance to the association's constituents, we have undertaken comprehensive consultation among the AAO board and the committee members, chapter volunteers and staff from across Ontario. We have already submitted two major briefs on the subject to the government of Ontario and have made numerous written and oral submissions. The recommendations which follow are the result of more than two years of both internal and external consultation.

The amendments we suggest today reflect the recommendations made in the association's winter 1994 brief titled Proposed MSAs: Implications for People Directly Affected by Alzheimer Disease.

Alzheimer disease and the long-term care service demand: Sheer numbers alone dictate that the major focus of long-term care will be people with Alzheimer disease and family care givers. Current estimates put the number of people in Ontario with Alzheimer disease at approximately 100,000, with the projected increase of 50% over the next decade. Population projections suggest that by the year 2000, even without the changes planned under long-term care redirection, more than half of all people living in long-term care facilities will be people with Alzheimer disease.

As for care in the community, estimates indicate that fully 90% of the people living at home is supplied by family care givers. Clearly, long-term care's commend-

able goal of maintaining people in the community for as long as possible has huge implications for this other massive group, family care givers of people with Alzheimer disease and related dementias.

As we indicate on our cover sheet, people directly affected by Alzheimer disease—that is, people with the disease and their family care givers—will form the second-largest category of users of long-term care services across Ontario. The largest category, we understand, is that broad group of people between 75 years and 85 years of age.

How well people who are directly affected by Alzheimer disease are served will determine the success of the long-term care programs. If the needs of people with the disease and family care givers are not addressed effectively, long-term care redirection would have been a failure.

Mr Bernard Leech: I'll talk about features of the disease and the applicability of long-term care goals.

Before reviewing the appropriateness of the services detailed in Bill 173, we believe it is necessary to examine some of the specific features of Alzheimer disease and the impact on both sufferers and family care givers.

Alzheimer disease is found primarily in older adults. It is, however, most definitely not part of the normal aging process and, as diagnostic methodology improves, it is being diagnosed at earlier and earlier ages. Early diagnosis and recognition of Alzheimer disease shows a growth in the early onset group.

Alzheimer disease is a progressively deteriorating neurological condition with no known cause or cure. It is marked by continued cognitive decline beginning with simple forgetfulness and ending with the inability to eat, to recognize loved ones and to control one's bodily functions. The diagnosis of Alzheimer's disease foreshadows a two- to 15-year lifespan of progressively increasing dependency, usually upon a partner, followed most often by institutionalization and inevitably by death.

Alzheimer disease causes a progressive and irreversible loss of mental function. The loss of mental function includes:

—Progressive and irreversible memory loss, and here I'll leave out the "progressive and irreversible" and just deal with the deficits;

—Loss of orientation skills, both of time and location;

—Loss of visual-spatial skills;

—Loss of concentration skills and thought disorder;

—Loss of abstract thinking skills;

—Loss of decision-making capabilities;

—Loss of ability to give directions for care;

—Loss of ability to carry out functions of daily living; for example, bathing, toileting, dressing, cooking and eating;

—Loss of language skills with eventual inability to communicate or speak;

—Loss of ability to recognize family, friends and self.

Progressive loss of mental function can result in a progressive loss of physical control, including a major

item, incontinence; the tendency to falls; the inability to walk; and eventual inability to function physically at all.

While many conditions may result in some of the deficits listed, only with Alzheimer disease are some or all of them present together, and they are present in irreversible and steady decline. It is this combination that makes Alzheimer disease so unique and the design of services so difficult.

A person with Alzheimer disease must depend on a care giver who can expect the individual to change personality, often becoming aggressive, to wander from home without warning and to lose all decision-making ability. In later stages, care must be given on a 24-hour-day basis.

Family care givers must be prepared to provide eyes, ears, hands and minds for people they love who are irrevocably and steadily deteriorating; people who may not be able to speak coherently, to think, to recognize family members, themselves, other people, places or things; who cannot make judgements or control their own bodies.

The impact of this exhausting responsibility on family members is magnified by the daily trauma of seeing a spouse, parent or relative become a needy stranger. Without assistance and relief, the economic and emotional stresses can destroy individuals and families. Failure to sufficiently support family care givers endangers both the care giver and people with the disease and leads inexorably to institutionalization.

The debilitating effects of Alzheimer disease do not fit into some of the commendable goals of long-term care, in that Alzheimer disease is not preventable; there is no possibility of remission or reaching a plateau; Alzheimer disease is irreversible.

The purpose of care is not rehabilitative but rather to maximize remaining functions and maintain a decent quality of life for as long as possible.

Ms Morris: The benefits of long-term care reform:

Aims of long-term care reform: The Alzheimer association applauds the dual aims of long-term care reform:

(a) To supply consistent and high-quality facility services for those people whose needs cannot be met in the community;

(b) To provide sufficient community and personal supports that will enable people needing long-term care services to live at home for as long as is possible.

The association lauds the attempt to integrate and systematize services that are often duplicated and overlapping; services that may be confusing to access; services which fail to put the consumer of services as the centre of the focus; services which, without reorganization, are increasingly fiscally unsustainable.

The multiservice agency concept: We reiterate our support for the multiservice agency concept with a focus on a consumer-centred one-stop shop, the availability of basic services across Ontario and local design of programs to meet local needs, but our concerns go further.

1020

The purpose of the act: As Bill 173 now reads, its pur-

poses do not include the provision of support services to those people forming one of the critical cornerstones upon which the laudable movement away from institutionalization is based: the family care giver.

Ninety per cent of care now being supplied in the community is provided by family care givers. Long-term care in the community for people with Alzheimer's disease and related dementias will depend on the ability of family care givers to give assistance for them to remain at home.

Recommendation: Recognizing that family care givers will be an integral part of the foundation upon which long-term care reform will rest, the Alzheimer association recommends that to section 1, purposes of the act, a further purpose be added along the following lines: "to ensure that sufficient services are provided to family care givers in order that they may provide needed care for family members to live in the community with due regard for the health and wellbeing of both the care giver and the person requiring care."

The association was disappointed that the vision expressed throughout the long-term care consultations is not reflected in the legislation. While we commend the inclusion of the bill of rights by which consumers may know what they can expect from providers, we find that the emphasis on the needs of the consumer and the quality of life that marked the consultation papers is missing in the bill. The goal of integrating community and health services appears in the legislation to have given way to a health model of rules and criteria driven by the system rather than the needs of the consumer or even the local community.

Recommendation: Given that the commendable vision articulated in the long-term care consultation papers, of a system which emphasizes consumer need and quality of life, has in large part been lost in the translation to legislation, the Alzheimer Association of Ontario recommends that the standing committee on social development strive to recapture the essence of long-term care reform and that the government of Ontario amend the legislation until it reflects more closely the original vision.

Alzheimer-specific concerns: Multiservice agency boards: The viability of long-term care reform for people with Alzheimer disease and related dementias depends heavily on the ability and willingness of family care givers to provide care which will prevent institutionalization. If people with the disease and family care givers are not to be put at risk, the adequacy of supports to the care givers is critical.

A glaring omission in the bill regarding MSA board membership gives us very deep concern in this area and serious pause about the legislation itself. Not only do we have strong apprehensions about whether sufficient supports will be established; we have grave doubts about the maintenance and monitoring of such supports when MSA decision-making does not require the input of people with direct knowledge of the needs of family care givers.

The bill does require an MSA board membership which reflects the diversity of people whom the board will serve. Considerations listed are gender, age, disabil-

ity, geographic place of residence and cultural, ethnic, linguistic and spiritual factors. The bill goes on to require representation from persons experienced in the health services field and the social services field.

However, representation from a major and critical group, family care givers, is not required. Without representation from this group, MSA boards will not be well informed about the supports, such as respite care, which are essential to family care givers in preventing premature institutionalization. This is particularly true when issues regarding people directly affected by Alzheimer disease are considered.

Unfortunately, at this stage it is most unlikely that people with Alzheimer disease themselves will be found to provide sustained representation on MSA boards across the province. Without their presence on the boards and without the presence of at least some family care givers, we anticipate misdirected MSA board decision-making of programs affecting people with the disease. Such programs include assessment and placement, as well as the delivery of Alzheimer-specific services.

Additionally, with the budgets for specialized programs being capped, we are concerned that the dollars necessary for essential specialized services for people with Alzheimer disease will be lost in the competing demands for specialized-service dollars.

Our recommendation: Recognizing that multiservice agency boards should reflect diversity of service users, and recognizing that decision-making by such boards should be cognizant of the needs of major long-term care service users, and given that the current legislation does not provide for inclusion on MSA boards of one of the largest groups of long-term care service users, people directly affected by Alzheimer disease, the Alzheimer Association of Ontario recommends that subsection 11(1) be amended to require representation by family care givers of people with Alzheimer disease and related dementias on all MSA boards.

Ms Susan Kitchener: I'll continue with the Alzheimer-specific concerns that the association has.

An additional one, besides the MSA boards, is the limits on programs that we believe are critical to our constituents. Because of the long-term and progressive nature of Alzheimer disease and the specific deficits it causes, the association continues to see difficulties in meeting the needs of people with the disease through generic community-based services such as those detailed in Bill 173. While we recognize that the legislation allows for the provision of specialized programs through MSAs, it is in the provision of these specialized services that we have our strongest reservations.

The capped budgets for specialized services pits the needs of our constituents against those of all other groups. In meeting the admirable goal of consolidation and integration of programs, we are concerned that those services which are essential to family care givers as well as those which are essential to people with Alzheimer disease may be lost among the competing interests of the major consumer groups. This will, we fear, be compounded by both cost containment and misconceptions about suitable services to the extent that our constituents

will be put at risk. Not only will the services required by our constituents be competing for part of the capped funding against the interests of different groups; they will be competing against each other. Funding care giver services may mean cutting services critical to people with Alzheimer disease. Providing sufficient funding for care giver services such as family counselling, respite care, friendly visiting, Alzheimer-specific education programs and peer support may mean that essential funding to maintain a specialized day program for people with Alzheimer disease and related dementias can't be provided, and providing funding for one component may be valueless without the other.

We believe that the component which might best serve to sustain people with Alzheimer disease in the community should be removed from this competition. Recommendations as to how this might be done follow.

Our third Alzheimer-specific concern is the generic adult day programs. Of all the services that can be offered to people with Alzheimer disease and related dementias, adult day programs dedicated for them come closest to meeting the goals and principles of long-term care redirection. They are key to maintaining the dignity of people with Alzheimer disease and related dementias and to preserving their independence for the longest time possible.

It is not possible, through integrated day programs, to maximize the remaining abilities of people with Alzheimer disease nor to provide the augmentation that will prolong their independence.

The purpose of these dedicated or specialized day programs is to maximize and prolong the remaining assets of participants. The activation component of such a day program focuses on the personal skills and interests of the participant, and, having identified them, provides the materials, tools and adaptive guidance to encourage the individual to utilize remaining skills. Such programs might include interaction with people with specialized communications and other techniques, prevention of sensory deprivation, amplification of long-term memory and peer support.

It will be clear, from the features of Alzheimer disease which Bernard listed, that the needs of people with the disease differ very greatly from people with, for example, physical disabilities. The steady decline in capability differentiates their needs from most people with other cognitive disabilities. Animosity, resentment and fear on the part of people with other disabilities are very often the result when people in the mid- to later stages of Alzheimer disease are included in integrated programs.

1030

Activities offered in specialized programs for people with Alzheimer disease recognize such differences. For example, more direct and ongoing attention and stimulation must be provided. Specialized communication techniques are utilized, as is specialized knowledge of altered perceptions that are affecting the person. Acknowledgement is given to the age of the participants when planning programs. The physical environment is of paramount importance, given the tendency of people with Alzheimer disease to dart off suddenly. Provision must be

made to handle disruptive and occasionally violent behaviour. Higher staff ratios are required.

Only people in the very early stages of Alzheimer disease will be able to meet the eligibility criteria for integrated programs. For example, the draft eligibility criteria for adult day programs contained in the consultation guidelines recognize the potential conflict in integrating the programs. Criterion 4 requires "that the applicant is appropriately served by the activities of the adult day program," and number 5, "that the applicant can cope with the schedule of the adult program."

Without adult day programs dedicated for them, most people with Alzheimer disease will be excluded from the very support that is essential to remaining in the community. Specialized programs are the only means by which the people with the disease who have no family care givers will be able to put together sufficient hours of assistance that will allow them to continue to live in the community. Additionally, such day programs may enable people with Alzheimer disease and related dementias to continue to live with working partners and other family care givers.

Our recommendations are, and this is a really key area for us, as I'm sure you can gather:

Recognizing the massive numbers of long-term care service users represented by people directly affected by Alzheimer disease whose needs must be met if long-term care reorganization is to succeed; and

Recognizing that without the availability of dedicated or specialized adult day programs, long-term care redirection will be a disaster for many people directly affected by the disease; and

Given the critical importance of such day programs to maximizing the remaining abilities and to prolonging the capacity to live in the community of people with Alzheimer disease and related dementias,

We recommend that subsections 12(1) and 2(4) be expanded and clarified such that adult day programs dedicated for people with Alzheimer disease and related dementias are included in the mandatory programs which must be delivered by multiservice agencies across the province.

Mr Leech: It's my privilege, on behalf of the Alzheimer Association of Ontario, to read our conclusions and concluding comments.

For people with Alzheimer disease to live in the community, dedicated adult day programs may be as critical as is assistance with the activities of daily living to some people with physical disabilities. We cannot urge strongly enough the adoption of our last recommendation. In it, we ask that adult day programs dedicated to people with Alzheimer disease and related dementias be listed in legislation as a mandatory community service. If the legislation is not clarified adequately, regulations must be developed under paragraph 2 of subsection 56(1), such that the large numbers of people needing this service will be covered. Without this change, long-term care as it is being redirected will fail a very large and growing number of precisely the people it is meant to assist.

The reorganization and restructuring of the long-term

care system is predicated on the ability of partners, families and friends to provide sufficient care for people to remain at home in the community. If, because of inadequate supports, these people are unable to fulfil those obligations, people who need care will be in real danger.

We find the implications of the contents of Bill 173 and, equally important, what is left out of the bill very disturbing. The bill gives neither legislative recognition of nor provision for the amelioration of stresses that will be imposed on family care givers, most of whom I need hardly remind you are women.

Without recognition in the purposes of the bill that community supports will be needed to assist family care givers in some instances, we have little hope of a successful system. We urge the amendment of the purposes of the bill to add the provision of supports to family care givers. I might add that this is especially important to the early onset group when one spouse may have to go out to work.

We urge the inclusion of family care givers as consumers of long-term care services in the legislation, as they were in the consultation documents. In particular, we urge their inclusion in the "diversity of the persons to be served by the agency," who must be reflected in the composition of multiservice agency boards of directors. This is especially important in the case of Alzheimer disease, where people with a disability cannot presently be expected to sit on the boards for sustained periods of time.

Unfortunately, Ontarians already have an example of the disastrous results that can rise from reform undertaken even with the best of intentions of the government of the day. Like the reform of long-term care, the reform of the mental health system in the early 1970s aimed to keep people out of institutions and in the community. Deinstitutionalization then proceeded without sufficient community supports in place. The results were near catastrophe for the very people whom the reform proposed to serve.

We urge the government to heed the warning of the experience of mental health reform. Our consideration of Bill 173 suggests that, at least for our constituents, we're about to step over the same precipice again, to move to community care with insufficient community supports in place.

The promise of the reform contained in the long-term care consultation documents was exciting. Bright, committed and knowledgeable citizens are working collegially through district health councils and communities right across this province to bring local reform into being. We urge the government not to dilute that bright promise. We urge the adoption of our recommendations to the benefit of the second-largest category of users of long-term care services, people directly affected by Alzheimer disease.

This concludes the presentation of the Alzheimer Association of Ontario. Again, we thank the committee for hearing from us and we are prepared to answer questions or hear your comments.

The Chair: Thank you very much for a very detailed brief. As I think you know, a number of your regional

associations have been meeting with the committee as well. We are, as always, tight on time. I will be able to allow one question from each caucus, but one only, and would ask as usual that members keep those questions short and sharp, beginning with Mrs O'Neill.

Mrs Yvonne O'Neill (Ottawa-Rideau): I thank you very much for this brief. You understand Bill 173 and you've studied it. I'm going to use my time to ask the parliamentary assistant, and perhaps the ministry staff, if your concerns about the inclusion of the adult day program are based in reality or can they give us some consolation that they will be included for sure under adult day programs. I understand exactly what you've said about that.

I also want a comment about care givers being left off the multiservice boards. I presume that's an oversight. I presume they, the people who wrote this bill, think that will just happen by chance. I think both of these things are worthy of amendments if the answers we get this morning are not what we hope for. Perhaps I can get a comment from the parliamentary assistant about those two, what I consider, serious concerns.

Mr Wessinger: I'll answer the first with respect to care givers. It's set out in the legislation that the board shall reflect a diversity of persons to be served. Family care givers are definitely persons to be served and they're definitely consumers, so they are to be covered under the consumer aspect of representation.

With respect to the adult care program, I'm going to ask Mr Quirt to reply to that one.

1040

Mr Geoff Quirt: Just further to Mr Wessinger's comments, I see no reason why an amendment that would clarify that family care givers are indeed consumers in the long-term care system wouldn't be agreeable to all concerned. Secondly, with respect to adult day programs a number of presenters have suggested that those programs, particularly those associated with long-term care facilities, should have the option of staying independent of the multiservice agency and continue to be funded directly by government.

I've indicated to the committee that the minister would be quite prepared to consider such a recommendation and Mr Wessinger's made the same remarks. In those cases it would require perhaps an adjustment to the bill to make sure that the 20% purchase-of-service limit wasn't a barrier to the ongoing development and support of a specialized Alzheimer day program.

Mr Jackson: I'm somewhat encouraged to hear that, but do we have the government's assurance that those amendments will be supported? Because the one that's of greatest concern is, as the point is made in this brief, that the two types of programs pull against each other and will limit access. To the extent that you're prepared to look at exemptions outside of the 20% rule for purchase of service for Alzheimer service, does that include respite services as well as, besides just, the day care program? The care givers' program, by extension, is equally important for the care giver, to give them access to respite. The most vulnerable people who are before us in this legisla-

tion are persons afflicted with Alzheimer and their families. Can we get a clarification on that additional point about respite services as well?

Mr Wessenger: Yes, I believe it's clear in the act that respite care for care givers is part of the mandatory services to be provided by the MSAs.

Mr Jackson: That wasn't my question. My question was if it would be subject to the same exemption rules as the delivery of Alzheimer programming for those affected. I'm saying that for an Alzheimer program to be effective in the province of Ontario, it has to deal with the afflicted family member and those family care givers. I mean, we've had testimony and I've had occasion to assist families with Alzheimer patients to use the administrative back door of family breakdown to get a person into a hospital or into a facility as a desperate plea to save the family care giver.

I'm asking if that respite component will also fall into the statement that Mr Quirt just made about the government's willingness to allow the Alzheimer program to exceed or go beyond the 20% restrictive rule. That's the clarification I was seeking, not what's in the bill. I'm familiar with that and so are our deputants.

The Chair: The parliamentary assistant and then we will have to move on.

Mr Wessenger: I think it's clear that, first of all, respite care and facilities are definitely exempt from the bill now. I think the adult day programs are something that is going to be looked at to see what mechanism can provide—

Mr Jackson: The answer's no.

Mr Wessenger: —the flexibility. That certainly is a commitment—

Mr Jackson: The answer's no.

Mr Wessenger: —by the minister, to consider the aspect with respect to adult day programs. But as far as respite community care is concerned, that would be part of the no special exemption, as I understand, for that.

Mr O'Connor: I appreciate you coming before the committee. You present a different view than we hear from a number of people.

You mention a cap. There certainly has been a cap in long-term care because the government commitment to long-term care has increased by over 54% into the community. This year it's going to be around \$850 million, so the money is definitely going into the community.

You illustrated on page 10 of your brief a really good reason why you need to be part of an MSA: the day programs. You talked about the need for your involvement. I certainly agree that the focus has to be on the consumer. In the special case that you represent, the care giver can best represent the consumer in this.

The question that I have for you is, the first presentation, and I don't know whether you were here for it or not, was from ALOHA, the public health units. They suggested that they can speak for the consumers. I wondered whether or not they could. I think that when we talk about consumers, and in this case family care givers, an elected council member doesn't necessarily

know the real needs and concerns of this type of a consumer of the service. I just wondered if you can give me your feelings on it. I think that it's got to be far more representative as far as the consumer is concerned and that this body may not be best equipped to deal with those special influences, as you put it so well on page 10 of your brief.

Ms Kitchener: Thank you for your comments. I of course would rather not comment on the ALOHA brief, but the reason that we continue to be concerned about the MSA boards—you've put your finger on it—is that there are two groups of people here who are consumers. One group of people, the care givers, might, through the provisions allowed in the act, by chance get elected occasionally, sporadically, throughout the province to an MSA board, in which case they can bring an understanding of the needs of family care givers.

The second group of people, who would be the primary consumers, the people who are the most vulnerable—people with Alzheimer disease—can't sit on the boards. I come from a long consumer background and so I have problems with saying that parents and relatives can represent the consumers. But in this case, at least, the viewpoint—no, it's not even the viewpoint—at least the concerns can be brought forward by somebody. We're very concerned that without family care givers of people with Alzheimer disease on every MSA board in the province, we're going to really overlook the needs of both sets of constituents, the two victims: family care givers and people with the disease. So we urge very strongly the amendment to the legislation.

Mr O'Connor: There certainly will be support by the government for an amendment to that section that deals with the family care givers. I appreciate you coming here.

The Chair: We have to move on; I'm afraid we're running a bit late. May I thank you, on behalf of the committee, for your submission.

Ms Kitchener: Thank you very much, committee members. I wonder if we could leave with you a particularly horrific article which I'm sure you've all seen. There are two articles on the effect of stress on both the person and the family care givers.

The Chair: If you would give it to the clerk, we'll have it circulated.

Mrs O'Neill: Mr Chairman, may I reiterate my request regarding the capping and the 10% and 20% and its implementation dates? We're in Toronto today. We have the ministry officials hanging around. I know we haven't got time for a technical briefing in the next week. It's critical that we know, so that we can all be speaking from the same text, what the rules and regulations and implementation dates are for the 10% and 20% capping.

The Chair: We'll direct that and get some answers. Can I just say to committee members, we have a very difficult day today and we are running a bit late, so if we could focus on the task at hand.

UNITED WAY OF GREATER TORONTO

The Chair: I call the representatives from the United Way of Greater Toronto. Welcome to the committee.

Mr Gordon Floyd: My name is Gordon Floyd. I'm

a member of the board of trustees of the United Way of Greater Toronto and a member of the government relations committee for the United Ways of Ontario. With me is Liz Mulholland, who manages our government relations programs.

I would like to begin by thanking the committee for this opportunity to share the United Way's response to Bill 173. I'd like to make it clear that today I'm speaking on behalf of the United Way of Greater Toronto. Many of the concerns that I deal with are shared by the United Ways of Ontario, but that organization is still finalizing its position and will come before you later with a written submission.

1050

For those of you who aren't familiar with the United Way movement, there are two or three paragraphs at the beginning of our brief that deal with it. I'm not going to read them to you. Maybe we'll help with some of your time problem.

This year the United Way of Greater Toronto allocated more than \$30 million to 193 agencies serving Metro Toronto. More than \$3.25 million of this was allocated to long-term care services. That's over 10% of the total allocations of the United Way. Clearly long-term care reform will have a significant impact, both on the United Way's member agencies and on how we ourselves allocate our funds.

For that reason, a year ago we established a long-term care task force with the dual mandate of assessing the impact of long-term care reform on our agencies that are involved in long-term care and assessing the United Way funding and the implications of long-term care reform for the allocation of United Way dollars.

Since then, we have been involved in the process of long-term care reform at many levels: in consultations with the Ministry of Health and meetings with the Premier's office, in active involvement on committees of the district health council, and in focus groups.

As volunteers, we have dedicated an unprecedented amount of time and energy to this work in recognition of the lasting impact that long-term care reform will have, and the consequent need to ensure that we get it right.

Throughout this process, we have attempted to be constructive, because we recognize the urgent need for reform and that the time for it is now. At the same time, we have expressed significant concerns with some aspects of this policy and, more particularly, with how it is to be implemented. Some of these issues have been addressed effectively by the government and others not so effectively. Still others are awaiting policy development.

We will continue to work as cooperatively as possible to meet the objective we all share, which is enhanced consumer access to more effective and efficient long-term care services. It's in this spirit that the following comments are made.

We understand that Bill 173 is intended as a general legislative framework and that the government is anxious to avoid being overly prescriptive in the body of the act. This has resulted in fundamental questions of policy being left for future development in the form of regula-

tions. As you know, the process of developing regulations is far less public and accessible than the legislative process. We're concerned that we'll be presented with a fait accompli on policy issues that properly require consultation with a broad variety of stakeholders.

I want to emphasize that by consultation we do not mean a quick flurry of meetings over the course of a week or so, but an ongoing process designed to ensure that as much information and expertise as possible can be brought to bear on these extremely complex issues.

We recommend that the working groups assigned to develop regulations and their terms of reference be widely publicized and that they be instructed to regularly inform all interested stakeholders of their progress, and to invite their feedback on policies under development. When they have completed their mandate, the resulting regulations should be released in draft form for a final consultation, with adequate time for stakeholders to properly review them and respond.

We also encourage the working groups to resist making definitive policy decisions where they lack adequate information. We've heard a variety of questionable statistics thrown around throughout this reform process to date. The notorious 40% for administration costs in community-based service providers is only one of those.

The fact is that we lack important data on many important areas of long-term care. As a member of the funding committee that was set up by the Metropolitan Toronto District Health Council, I've got firsthand experience with this. That committee has been disbanded because it had no information to work on. The long-term care office couldn't supply information, the ministry couldn't supply information, basic financial information about the cost of the long-term care system as it exists now, and nobody has any idea of what the cost impacts are going to be as this transition takes place.

The solution is not to proceed on the basis of unsubstantiated assumptions and ballpark guesses. Instead, we need to identify the policy areas where more research is needed or where pilot testing is needed and address them accordingly. This will slow the process, but you cannot build policies that work any other way.

The remainder of my comments concern four specific issues that the United Way has identified as priority concerns: voluntarism, community responsiveness and accountability, funding, and transition. Let me begin with voluntarism.

Volunteer retention and support during transition and under the new system has been cited repeatedly as a significant concern by United Ways and other organizations. Volunteers are an important resource base and are integral to ensuring the continuing availability and quality of services, community support for long-term care services and community accountability.

With the amalgamation of existing agencies, there is unquestionably a risk that some volunteers will be lost in the transition. The extension of the MSA implementation deadline has alleviated this problem to some extent by allowing agencies to better plan and manage the transi-

tion. It is none the less a continuing concern. At the same time, we need to ensure that all MSAs provide adequate funding and supports to recruit, train, retain and recognize volunteers.

It's interesting that the planning documents that came out of the Ministry of Health did not originally address the problem of volunteers and the volunteer slippage that we all expect to occur. Because of the protests, I'm pleased that the ministry has, at least as an afterthought, started to deal with this issue.

United Ways of Ontario has recently received funding from the ministry to conduct research on appropriate roles for direct service volunteers in the MSAs and on the administrative supports that will be necessary to ensure their continuing and effective participation in the delivery of long-term care services. We view this as a sign of the government's interest in sustaining voluntarism in the long-term care sector and we look forward to presenting the results of this study to the minister in December.

The next concern I'd like to address is community responsiveness and accountability. This concern is often cited in terms that MSAs will be government-run. Ministry staff have misinterpreted this literally to mean that people think MSAs will be branch offices of the ministry. They're missing the point. What people are saying is that they are concerned that MSAs are going to be too bureaucratic and awash in red tape. A community board by itself is no guarantee that this will not be the case.

There are a number of factors, in our view, that will determine whether or not MSAs ultimately prove to be too bureaucratic. The first of these is size, but only to the degree that decisions can be made faster in an agency with two layers of staff than one with five, and that front-line staff will probably be more involved in decision-making in smaller agencies with fewer layers. That's not to say that all small agencies are models of flexibility and responsiveness—I'm sure we all know otherwise—or that all large agencies are bureaucratic. Larger agencies, however, must actively decentralize their decision-making if they want to remain flexible and responsive.

The second and perhaps most determining factor will be the amount of regulation imposed on MSAs by the province. The greater the degree of regulation and standardization, the less decision-making authority MSA boards will have. At the same time, each and every regulation cannot help but add to the administrative burden of the MSA. Implementation, monitoring, reporting, enforcement and evaluation all require staff and volunteer time and labour, which costs money, money that would otherwise be paying for direct services. Clearly, we need some regulation to ensure equitable, consistent and quality services. However, the drive to regulate ultimately must be weighed against its cost in lost services and lost autonomy at the community level.

Given that the goals of this reform are to shift resources from administration to direct services and to make services more responsive to consumers, members of the Legislature should be taking these cost concerns very seriously. In many respects, providing agencies and ultimately MSAs with the resources, information and

supports they need to meet the government's policy objectives would be a far more effective approach than prescriptive regulations. Let me cite an example.

When United Way decided to make accessibility one of its funding criteria, it established an anti-racist and multicultural organizational change program to provide information, training and consulting to agencies engaged in improving their accessibility. Over 100 United Way agencies have now gone through this process, most with impressive results. The key to this success was not only in our requirement that agencies be accessible, but that the supports were available to make it happen.

1100

Metro's ethnoracial communities continue to express concerns about the ability of MSAs to respond adequately to their needs, and the homosexual community affected by AIDS appears to have been virtually absent from the policy process to date. The government must ensure that MSAs are fully accessible. We recommend that it make necessary information, training and supports available to agencies forming MSAs in order to assist them in meeting this objective.

Also on this note, I'd like to raise the issue of the 20% guideline for the purchase of outside services. In our view, this is another impediment to community responsiveness and local accountability in the MSAs. Our recommendation on this is that there not be a hard 20% guideline, that the appropriate level for purchase of outside services would be decided by the DHC in consultation with their local planning committees.

My next point concerns accountability. Bill 173 and much of the government's long-term care policy to date contain a variety of mechanisms to ensure MSA accountability to the government. In the legislation are additional mechanisms which, while not perfect, do point to some level of accountability to consumers. There is nothing beyond the existence of a community board and membership, however, to ensure accountability to the broader community in all of its diversity.

Again, this is an area where the sharing of information and tools could be effective. United Way, in conjunction with its agencies, recently developed an evaluative framework to assist agencies in assessing how well their programs are responding to community priorities and needs. This framework is attached to our brief for your reference, and we would be pleased to discuss it further with any interested ministry officials.

Evaluation can be extremely expensive. We recommend that the government ensure its evaluation framework for MSAs is designed to avoid elaborate and costly processes that divert funds unnecessarily from direct services.

On the question of United Way funding for MSAs, I'd like to clarify that each of Ontario's 45 United Ways is completely autonomous with regard to its membership and allocations decisions. While United Ways do have a provincial association, United Ways of Ontario, it does not make policy decisions of this nature.

Historically, most United Ways have tended to not fund mandated services on the premise that these are the

responsibility of the government. That being said, there are exceptions.

The bulk of United Way funds is allocated to member agencies which are regularly reviewed against locally determined criteria to assess their performance and need for United Way dollars. All agencies must be registered charities. Consequently, United Way funding for MSAs in most communities will be contingent on the MSA meeting the local United Way membership criteria and agreeing to comply with membership requirements like a blackout period for fund-raising during the United Way campaign.

Some United Ways may choose instead to negotiate an alternative funding relationship with the MSA due to its distinct nature as the primary service provider of community-based long-term care services, and still other United Ways may choose not to fund the MSAs at all, but to support non-mandated related services that are delivered outside the MSA structure.

In short, there are a range of funding options open to United Ways, and each will make its own decision when the appropriate time comes. I can safely say, however, that United Ways have no intention of withdrawing funding from services to seniors and the disabled, especially since there is substantial risk that many donors who have been supporting agencies that are now going to be absorbed into MSAs will stop contributing. It is simply a question for us of how United Way dollars can most effectively be reallocated under the new system.

With regard to government funding, it's clear to anyone familiar with the long-term care reform policy that one of its primary purposes is to equitably ration services when needs outstrip available funding. The current existence of waiting lists indicates that this is already the case in some service areas. The government, however, has created expectations that service levels will increase dramatically as a result of this reform.

We acknowledge that the government is putting new money into long-term care services to create services in areas where there are none or where too few exist currently. However, no new dollars will be spent on existing services, services which have been inadequately funded for years.

At the same time, ministry officials have indicated to us that many costs, in particular wage costs, are expected to increase. Wage costs are expected to increase an average of 20% over the course of this reform due to the expansion of pay equity and, to a lesser degree, increased unionization. One of the United Way agencies has calculated that its payroll, which is now \$3.2 million, will increase by \$600,000 per year as a result of the application of pay equity.

Without additional funding, the only way to absorb these costs is to significantly reduce services. We wonder if this part of the policy has been thought through carefully enough and whether the hard decisions about the reduction of services should be left to the DHCs, as is currently the case. We're not attacking pay equity or unionization; we're simply illustrating why we should not be generating false expectations as to what these reforms can and cannot deliver.

This brings me to the subject of transition. We'd like to urge the government to begin addressing some pressing questions arising from the implementation of the new system. We're being asked by agencies how to estimate severance costs for the entire agency as they begin to plan for possible amalgamation or closing down. We understood from the ministry that the province would take responsibility for all severance costs resulting from this reform. Apparently, this information has not been communicated to agencies. Does the government still intend to assume responsibility for these costs? What about other transition costs, such as legal and consulting fees, disposition of agency assets, counselling and adjustment for laid-off employees?

We recommend that the government examine, in consultation with service providers, the range of costs associated with transition to the new system and issue a clear statement as to what costs it will assume and what agencies are to be responsible for.

As well, there should be some examination of the labour relations issues facing agencies as they undertake amalgamation. In the event of an amalgamation, will existing workers simply be inherited by the MSA? Will they have to requalify for their jobs? Will non-unionized workers have the same seniority rights as unionized workers? All of these questions are contributing to growing uncertainty and insecurity among agency staff across the sector. Are these questions all to be resolved at the local level, or will the government be providing some guidance and support? We recommend that the government ensure that agencies have access to the legal, labour relations and human resources expertise they're going to need to manage this complex transition.

In summary, we urge the government to be as consultative as possible in developing the regulations to accompany this legislation. At the same time, we believe that providing agencies with the supports they need to effectively implement the government's policy guidelines can often be more effective than prescriptive regulations. Regulations under consideration should be weighed against their cost in added administration, loss of community responsiveness and dollars diverted from direct service. Evaluation frameworks should be assessed against their potential costs as well.

We encourage the government to avoid creating unrealistic expectations as to what this reform process can ultimately deliver in terms of expanded services, and look forward to clear responses and additional support from the government on the many transition issues that our member agencies and others are confronting.

Thank you once again for this opportunity to share the United Way of Greater Toronto's response to Bill 173. Your consideration of the issues I've raised is greatly appreciated, and we'll be pleased to entertain questions.

1110

The Chair: Thank you for the submission and also for the attachment you have provided. Again, we're a bit tight on time, but I want to make sure that we get one question at least from each caucus.

Mr Jim Wilson (Simcoe West): Thank you very

much for what is an excellent and comprehensive brief. I have a lot of questions I'd like to ask you. In fact, a number of the things that you've brought up are indeed very disturbing.

I'm very concerned that this bill may cause a number of your donors to stop contributing. I'm very concerned about volunteers. I want to know on both of those fronts, given that this government has a habit of not changing legislation in very significant ways after public hearings such as this—I expect the bill will go through pretty much intact, even though at this point certainly my caucus colleagues and I won't be supporting it because we just think there are too many problems.

A number of the concerns you've raised in I think a very polite way are actually things that cut to the heart of this legislation. I mean, the 80-20 rule is NDP all the way. We're going to introduce an amendment to get rid of it, but I suspect you're going to see some version of it still in there, and a number of these other things too.

So I want to know how we can mitigate the effect on donors and volunteers, any good advice there.

Secondly, I have a question for ministry officials because this is astounding on page 11 when the United Way of Greater Toronto has heard that costs will actually go up as a result of increased unionization and pay equity. Given that this government hasn't provided, as you pointed out earlier in your submission, anything whatsoever to tell this committee or to prove to this committee that there would be savings with the new MSA model and that administrative savings would in fact go to front-line services, certainly what you've said on page 11 flies in the face of the government's own assurances that there would be savings.

So I want a response from the parliamentary assistant: Is this 20% projection in increased costs true, and would you please provide this committee with the actual documentation on the number crunching you've done to date?

Mr Wessenger: I think probably we can ask ministry staff to provide details with respect to the pay equity aspect, but my understanding, and perhaps ministry staff can correct me, is that the 20% aspect is not going to come out of agencies' budgets. I think the point being made here is that pay equity is costing the government as a whole additional moneys, and that means then in the whole perspective that it's moneys that are not available for provision of services in general across the whole—

Mr Jim Wilson: They're saying that as a direct result of this bill, they've heard there will be a 20% increase in costs stemming from pay equity and increased unionization. Do you have something you're not telling this committee?

The Chair: Just to be clear here, Mr Wilson, perhaps we could just ask the deputants, to make sure we understand what your understanding is on the 20% so the parliamentary assistant can answer that.

Mr Floyd: Our understanding is that there will be a 20% increase in compensation costs across the board arising as a result of primarily pay equity, and also increased unionization. I cited the example of the one agency where they have done the arithmetic and it does

work out to about 20% based on pay equity.

Interjection: Is that right?

Mr Jim Wilson: That's astounding.

Mr Wessenger: I'll ask ministry staff to clarify, but my understanding in principle is that pay equity costs are picked up primarily through increased payments generally and will not come out of the particular agencies' budgets. But I'll ask if I'm correct in that.

Mr Quirt: The ministry has not calculated the cost of pay equity for workers in the community service system because that process is ongoing. As various workers benefit from the pay equity legislation, costs can vary depending on the community and the workers through which the value of their jobs is measured.

Pay equity costs of course would be incurred as a result of paying workers closer to what their job is worth, whether there was an MSA or not, and even before pay equity a number of governments have made efforts to improve the wages of homemakers in the province. So pay equity costs have not been calculated specifically.

As Mr Wessenger has indicated, there is additional support available to cover pay equity costs recognized government-wide, and those costs would have happened when workers had an opportunity to have their jobs re-evaluated, whether they worked for an MSA or worked for the agencies they're with now.

The Chair: Thank you. Ms Haslam.

Mr Jim Wilson: Could I have the first part of my question answered?

The Chair: I'm sorry. Yes.

Mr Jim Wilson: How can we now in this legislation minimize the effect of it on your donors and volunteers?

Mr Floyd: I think that both of those concerns, about a dropoff in donors and a dropoff in volunteers, are related very much to the perception and the belief that MSAs will be much less community-based than the existing system and the existing agencies. People who give money to a local Meals on Wheels or any kind of local agency now feel some sense of belonging to that agency and feel some sense of that agency as part of their community. That's why they support it, either as donors or as volunteers.

I think anything that can be done in this legislation, and we've referred to some specific measures, to ensure that the MSAs are as community-based and as community accountable as possible will go a long way to protecting the donor base that now exists and the volunteer base that now exists.

Mrs Karen Haslam (Perth): I'll make my questions as short and as succinct as the other two. It's always a pleasure to have Mr Wilson on the committee. We've worked together before. He always brings such a joie de vivre to a committee.

I was going to talk to you about the community responsiveness and accountability, because I agree, I think in the legislation we have to be sure people see an MSA—and that's what I see in this legislation—as being more accountable to consumers. When we have local boards responsible, we have more accountability not only

to consumers but to the members of the board, and that board must be accountable to their members, to the consumers and to government, and so I agree with that.

But I disagree with you about the loss of volunteers. I see other areas where government funds and the volunteers and the fund-raising are still there. I look at hospitals that are supported by government and have many volunteers. I look at seniors' homes that receive funding from government and maintain a very active and very good base of volunteers. I look at the education system, which people would see as a large bureaucracy or a government-funded entity. Volunteers are very active and very prevalent in those.

When we can take 1,000 fragmented agencies and streamline them to one board that is more accountable, and that's what I'd like to see, more accountability to the consumers, which is what somebody just mentioned before us, more accountability, I see that as being beneficial. I'm not sure that you would lose your ability to fund-raise, and by designating and still having certain programs within an MSA, like Meals on Wheels and like homemakers' programs—for instance, when I donate to the United Way, I can pick off where my money goes. Wouldn't that avenue still be open, or would you be changing the type of programs you support and not allowing me to say, "I want to support the Meals on Wheels; I want to support the homemaking"?

Mr Floyd: I don't think we'd be changing on that score at all.

I think your example of education and hospitals is an interesting one. In my real life, when I'm not a United Way volunteer, I'm director of public affairs at the Canadian Centre for Philanthropy. We recently released a study a few months ago about the charitable sector, which, as you know, includes hospitals and educational institutions. It was a profile of the sector as it exists in Canada. One of the very interesting findings from that profile is that the lowest level of voluntarism happens in universities, followed quickly by hospitals, and that all other areas of the charitable sector have a much higher participation of volunteers than those two. Now, this study didn't delve into all of the reasons for that, but I wouldn't be at all surprised if it has a lot to do with the perception that those are essentially government agencies.

There are many people in the long-term care system now who envisage the MSAs that are going to emerge from this reform as something like hospitals, as having a governance structure that's something like hospitals and having a degree of accountability to the community that's similar to hospitals. Certainly in a large metropolitan area, and I don't think this pertains as much in smaller towns and cities in Ontario, but certainly in Metropolitan Toronto, I don't think there are many people who feel that their hospitals are particularly community accountable or that their hospital boards are that way either.

1120

Mrs Haslam: In my community it's different. I see the volunteers committed to the community. Some people in a volunteer situation volunteer for 11 different agencies or 11 different programs and they do things through my church or they do things through Meals on

Wheels, so the commitment is there to the community. Maybe it isn't Metro Toronto, but the volunteer base in my community I think will still be there, because their commitment is to the community.

Mrs Barbara Sullivan (Haltont Centre): I appreciate what is a very thoughtful and thorough brief. I'm going to move away from the volunteer activity for the time being, although I think you've made your point, that that has to be emphasized a great deal more. I'm going to move back to some of the areas which you have alluded to throughout your brief with respect to the responsibilities of the DHC in shaping an MSA to meet the needs of a community.

My very great concern is in fact that this legislation prescribes a model that must be put into place right across the province; that it is not a model that many communities have already indicated they want, that they feel will meet their needs; and that there's no place for special needs, some of which you've mentioned, but I think of needs for people with dementia. You've mentioned the AIDS patients. I think of other special diseases. I think of faith-based needs that are not met through this particular model.

One of the areas where you have suggested there ought to be flexibility is an area where we are putting forward an amendment, on the 20% rule. I think your suggestion that that 20% decision, made by the DHC, or a decision on the level of purchased services made by the DHC, is probably an appropriate one. Certainly we will take a very hard look at that.

I'd like you to comment, if you would, on allowing DHCs the flexibility to select another model, which is certainly the direction that we are leading into. We feel we will lose too much with this prescribed model the government has put forward and in fact we'll lose a great deal of the culture and basis of our communities in Ontario.

The Chair: I regret I have to request a reasonably brief response.

Mr Floyd: It will be a brief response; it can be a brief response. I agree quite strongly with what Mrs Sullivan is suggesting. I think the experience I have had in the DHC planning process around long-term care reform here in Metropolitan Toronto has not been a very encouraging experience. I've been involved in a total of three different task forces and committees in this DHC, so we've been exposed to a lot of people who are involved in the planning process and in the attempt to implement this policy in Metropolitan Toronto, and I can say quite frankly and quite honestly that those committees have continued to exist only because people have said, "Well, the government's decided that this is the way it's going to have to be, so we're going to have to try to figure out something that doesn't do too much violence to the services and the system, that tries to achieve some of the accessibility goals and equality-of-service goals that are the objective of long-term care reform, but tries to preserve as much as we can of the community spirit, the sense of involvement and the sense of responsiveness that we now have in the existing agencies."

I think there's no question that there's virtual consen-

sus among the people I've dealt with in this reform process that they would like to see a much larger role preserved for the existing agencies within the umbrella of an MSA-type system that would improve accessibility and ensure equivalence of services throughout the province.

Mrs Sullivan: That's what we've been hearing through the province, too.

The Chair: I regret time means we'll have to move on, but I want to thank you again for the presentation and the attachment which you brought with you.

MUNICIPALITY OF METROPOLITAN TORONTO,
HOMES FOR THE AGED DIVISION

The Chair: I call on the next witness, from the municipality of Metropolitan Toronto, homes for the aged division. Welcome to the committee.

Mr Dennis Fotinos: My name is Dennis Fotinos. I am a Metro councillor and I'm also the chairman of the community services and housing committee. I have with me today Ms Sandra Pitters, who is the assistant general manager for the homes for the aged division, and Mr Chris Brillinger, who is also with the community services and housing department with the grants division.

I am pleased to have the opportunity to address the standing committee on social development on behalf of the municipality and to share with the committee some of our observations and concerns with respect to Bill 173.

Metro has been in the business of long-term care since its inception in 1953. We currently operate 10 homes for the aged, a large supportive housing program and a number of community services, including meal services, adult day programs and our homemakers' and nurses' services program.

We are the largest provider of long-term care in the province, operating close to 2,700 long-term care facility beds and 405 beds in the supportive housing program and providing services for over 25,000 consumers living in the community on an annual basis. In addition, through our community services grant system, we directly fund 78 community support agencies and elderly persons' centres in the amount of approximately \$3.5 million annually in municipal dollars.

In total, Metro contributes approximately \$31 million annually to the provision of long-term care services for the combination of long-term care facilities, supportive housing and community services. Considering solely those services directly affected by Bill 173, we contribute approximately \$6.5 million annually in municipal dollars.

However, our commitment far exceeds our financial contributions. We have a strong commitment to serving our community. We have demonstrated this through our long and successful history in planning, managing and delivering high-quality long-term care. We have continuously improved and expanded our care and service system because of this commitment to community service. Our record for excellence and for innovative and consumer-sensitive service is second to none.

We have seen many changes in long-term care since Metro's inception in 1953. However, the most substantive changes have occurred within the past 18 months, first

with Bill 101, then with Bill 120 and now with Bill 173.

Not only have these bills radically changed the long-term care system, they have fundamentally changed the relationship between the municipality and the province and the role of the municipality in planning and managing services. Therefore, I find myself in a dilemma in addressing you today. While I can assure you that Metro is supportive of the broad aims of this bill, that is, the effort to make the system more efficient, accessible and accountable, we have strong concerns about the means envisaged to achieve those ends and find it impossible to support a number of the provisions within the bill.

Specifically, we have concerns about the bill's impact on a continued municipal role in the long-term care system, in particular with respect to the planning and service coordination functions.

We find incongruity between this bill and the province's stated principles of redirection. Some members of the committee might recall that when Metropolitan Toronto addressed the committee with respect to Bill 101, the Long-Term Care Statute Law Amendment Act, we endorsed the vision and general principles of long-term care reform but raised strong concerns that good intentions might be lost in implementation. Those fears were well founded. Bill 101 has turned from concern about care and service to one issue, that of dollars. The realities related to insufficient funding and staffing and stability have taken the foreground.

We don't want the same thing to happen to Bill 173. Therefore, we must again voice our strong concern. The vision reflected in the values and principles of reform has been lost. This bill does not express the quality-of-care and quality-of-life principles that were so much part of that vision.

Despite a well-meaning attempt, this legislation is flawed to an extent that it will jeopardize what is good in the existing care system, and it is impossible for a coordinated, effective system to emerge as a result of its future proclamation. In other words, we're throwing the baby out with the bathwater. Indeed, this bill destroys grass-roots community service programs as we know them. We predict that if Bill 173 is proclaimed as currently drafted, there will be a high price to pay in the loss of volunteer hours and local community identity, as was noted earlier by the previous speakers.

1130

Most alarming is the fact that the legislation entrenches a rigid new system, based on eligibility criteria, rules and regulations and provincial control, with no guarantee that it will be more qualitative or effective than the one we now have. Even though there is a four-year legislated transition period, the dynamics of organizational and systemic change will result in unforeseen and undesirable, we believe, impacts. Enormous human resource issues will be encountered. However, this legislation is very rigid and prescriptive, detailing the mechanics of the proposed system to an extent that it will make it impossible to accommodate future changes. Legislation is not the place to be overly prescriptive, although I will acknowledge that some details of the system belong in regulations and policies.

I'd like to raise two general concerns at this point prior to getting into the specifics of our presentation.

First, I must protest the time frame provided for response to the draft legislation. The bill received first reading on June 6 and second reading on June 15. We're now in the midst of August and we're already in the middle of the schedule for public hearings. Many boards of voluntary organizations, and indeed many municipal councils, I think, do not hold regular meetings during the summer months, at which time they could analyse the bill and make constructive comments.

As previously stated, Bill 173 radically changes the long-term care system. It affects the way in which communities will redefine the mandate of their community agencies and the governance of a crucial public trust. I urge you: Do not rush this bill. It is too important to the future wellbeing of seniors and persons with disabilities.

Our first recommendation is that we recommend that you extend consultation respecting Bill 173 until at least November of this year in order to allow municipalities and voluntary organizations ample time to consider the impact to their communities and to respond appropriately.

Also, I must raise concern that this legislation reinforces an artificial distinction between facility-based and community-based care that is inappropriate and unnecessary if the primary purpose is to ensure that consumers have access to appropriate care and service. I can find no statements in Bill 173 that speak to the original vision of meeting consumers' needs by creating an integrated health and social services system.

I'm sure the committee is aware that Ontario is only one of many provinces restructuring their long-term care systems. We should critically examine other jurisdictions before dismantling our current service system. New Brunswick recently redirected its resources from facility beds to community programming. However, the province redefined the mandate of long-term care facilities, broadening their scope of services to become the primary providers of a full continuum of long-term care services. For example, one facility now offers Meals on Wheels, home care, relief and a host of other services in addition to the long-term care facility. New Brunswick has recognized that community services offered by long-term care facilities contribute to building sound linkages between the facility and community and utilizes resources effectively.

The artificial barrier between facility-based and community-based long-term care created by Bill 173 must be removed.

I'd like to get into the specific recommendations that have caused us concern. I hope that this overview will lay a foundation for dialogue with the committee and certainly in the Legislature and perhaps at the end of the presentation.

Though there are some areas of strength in Bill 173, we also see negative implications, particularly in the areas of provincial control, system quality and effectiveness, community accountability, funding and consumer choice and representation.

First, the issue of provincial control: The province

appears determined to introduce overly prescriptive legislation that virtually assures the development of a rigid, inflexible and hard-to-change community services system. I think that's been echoed by the previous two speakers as well. I must ask you, to what end? What people asked for was improved access to services, elimination of repetitive assessments and an improved information and referral system. They did not ask for provincial control. Yet this bill legislates everything, right down to the relationship between a consumer and the service provider.

While the drafters of this legislation developed a guiding bill of rights, the requirement that all service providers simply accept these legislated rights rather than develop rights documents with the participation of their boards and consumers that are based on the legislation is wrong and does not reflect the principle of consumer participation.

Much of the detail in this bill centres around rules: rules about multiservice agencies, rules governing approved agencies, rules governing service providers and rules about revocation and takeover power. The detail in these sections of the bill is overwhelming. I don't think it's desirable for the province to attempt to micro-manage a system of community services. That role should be left to the regional and local level.

There is an inordinate emphasis on the minister taking control and operating agencies and facilities which do not meet ministry management criteria or which choose to relinquish control to the ministry. While it is appropriate that the province make due provision for the protection of vulnerable consumers, the legislation emphasizes the issue of ministerial takeover to an extent that could well indicate a profound lack of confidence in the governance of all community-based agencies, including charitable and municipal homes for the aged.

The prescriptiveness must be removed from the legislation in order to avoid the introduction of a rigid, inflexible system that does not meet future needs. The degree of ministerial control and takeover power must be reduced.

The next issue is that of system quality and effectiveness. The province has developed the MSA concept in the belief that it will solve the problem of a fragmented and confusing system of long-term care. In fact, I think they've missed the boat. The real problem is simply fragmented service delivery, which only requires improved coordination as a solution, not the elimination of community agencies that have consistently demonstrated flexible, quality service.

The province has gone too far in its reform agenda and is now creating instability in community agencies that is certain to have a negative effect on consumers and on system quality and effectiveness. Development of an effective, integrated information system would enhance the coordination of community services and eliminate the perceived need for a complete overhaul of the way service is delivered by community-based agencies.

There is only one clause in Bill 173 which speaks to quality management. There are many clauses which address provincial inspection. Bill 173 makes an incorrect

assumption that increased quality will result from a strong provincial inspection and takeover process. This is not the case. I believe, and the municipality believes and our staff believe, that quality will only result from the commitment of boards to assure quality in their own operations.

It is not in the public's best interests to establish a costly, inflexible, bureaucratic inspection process if it is not going to result in a better outcome to the consumer. The province needs to respect, trust and support the governance structure of approved agencies rather than interfere or take over the role of governing.

Also, this bill limits an MSA's ability to purchase rather than directly provide services to 20% of its budget within each program area. Again, this was echoed earlier. The prescription contained in this bill may not be appropriate to meeting the needs in many communities across the province. Indeed, looking to Metro where our district health council is planning for 15 to 20 MSAs, we have concerns that gaps and inequity in service levels will emerge. These might best be responded to by Metro-wide approved agencies. To cap purchased service at 20% is premature and misguided. Rather, we must concentrate on making best use of existing resources on behalf of consumers.

We recommend that MSAs be restructured to provide primarily a coordinating function. The provision for purchase of services must be expanded.

I'd like to deal at this point with the community accountability issue that's been raised. Presumably, district health councils across the province are working within their respective communities to design and develop MSAs. Yet before the DHCs have designed MSAs, the province has prescribed the form, administrative and governance structures, accountability and service configuration of the agency. The legislation entrenches a cookie-cutter approach that may or may not be effective. This hardly constitutes sensitivity to community needs.

The bill also directs the minister to consider all other approved agencies prior to considering a municipality or a board of health as an MSA. Organizations are at levels of government of elected representatives that have been providing this service for a long time. This is particularly offensive to a municipality such as Metropolitan Toronto which, as I said earlier, has a strong history and traditional role in planning and delivering community services, and we are a significant funder. If we're not doing the job correctly, eliminate Metro. Municipalities should be considered first, not last. They have the structure in place to ensure community accountability and service responsiveness.

The minister is permitted to designate more than one MSA to a geographic area, but the bill does not specify that when multiple designations are made, they should reflect the diversity of the community. For example, Metropolitan Toronto has a strong network of both mainstream and ethnoracial agencies. It is our experience that this mix is the preferred option for service delivery in our community.

With respect to DHCs, this bill puts forward a legislative framework and increases the power and scope of

authority of DHCs related to planning and making resource allocation recommendations about community services. This was a traditional role of municipalities, and the province virtually ignored municipalities. They did not involve them in any discussions prior to making this decision.

It must be remembered that district health councils are unelected. They are intermediate bodies that serve as liaisons between local governments and the province and may actually represent a barrier to direct accountability. It is our belief that the allocation of resources and the balancing of priorities are functions of the municipality, which is an elected, local body with clear community accountability.

The province must engage municipalities in joint decision-making regarding the future system of long-term care community services and recognize and reaffirm municipalities' legitimate role in planning and delivering community services and extend this role to cover resource allocation recommendations.

1140

Next, there are some very important issues around funding. The province must not reform community services and, at the same time, not be clear about the amount of money needed to sustain the reformed system, nor about the amount of money it can provide.

We should learn from the errors made with respect to Bill 101. We need to stabilize community services, and clearly there are practical limitations on the province's ability to fund all services. For taxpayers, a concern that is just as important as maintaining consumer dignity and independence is the cost of the system. Based on the experience of facilities following the implementation of Bill 101, the prospective cost of implementing Bill 173 is extremely high. The province does not have the resources to underwrite the entire system and to forego current revenues derived from municipal, voluntary and user contributions. Yet the province has not involved the alternate funders in any way in planning this revised system; not one discussion has taken place.

Using our own municipality as an example, Metro contributes \$6.5 million annually to agencies and organizations that will be affected by this bill. Other alternate funders, such as the United Way previously and charitable organizations, contribute approximately \$6 million. It is, I think, irresponsible on the province's part to unilaterally create a new system while at the same time to hope and expect alternate funders to keep funding.

I need to inform you that Metropolitan Toronto council will fund those organizations and initiatives which are consistent with its own strategic plan and social development strategy, and those might not be the same agencies as in the past that might now be subsumed by the emerging MSAs.

In the absence of adequate resources to the long-term care community system, needs will not be met and more consumers will fall through the cracks. Inevitably, new services will be created to address the needs and Ontario will return to the fragmentation that has plagued us in the past. Even worse, with the current expectations by

consumers of an improved and enriched system, new fragmentation will be devastating.

The province must release information with respect to service needs projections and cost analysis prior to third reading.

In addition, the bill specifies that there can be no charge for certain services. Historically, many services have been operated on a user-fee basis with a simple, non-intrusive means test. In this way, seniors were able to maintain the dignity and independence of paying for their services. Indeed, in Metro alone, home support user fees in the past totalled approximately \$4.9 million annually. The province must re-examine the line that has been drawn between what is fully paid and what is subject to user fees. In addition, this bill introduces inequity in charging for services when the application of a user fee is dependent upon a determination by a third party or whether services are or are not essential.

We recommend that the province adopt broader application of user fees with a simple, non-intrusive means test.

Last, and perhaps most important, is the matter of consumer choice and representation. Although the legislation recognizes the importance of individual needs, meeting those needs does not appear to be a priority. This conclusion is reinforced by the concept of access as defined in part I of the bill: Access is based on meeting eligibility criteria enforced through uniform rules and procedures. The idea that consumers must be assessed using consistent criteria so that their needs can be met within the system's resource capacity appears to have been lost. The focus on the consumer is not reflected in the draft legislation.

In addition, by decreasing the number of community agencies and creating large MSAs, the province is decreasing consumers' option of choice. In a monopoly, which is what the proposed MSAs would be, no motivation is built into the system to care about what the consumer thinks or to improve quality or cost-effectiveness. Consumers will have to report dissatisfaction to the same organization that determines eligibility and delivers a service. Apprehension over the result of complaining is exactly the opposite of what the province should be seeking.

We recommend that consumers be given more choice in the service they receive, the extent of each of those services and the provider of those services. A menu approach which reflects consumers' needs and not providers' practices is required. Further, the voices of people who use the services must be adequately represented.

The bill describes an appeals process. However, the prescribed process is not user-friendly and is quite time-intensive. This may well act as a barrier to consumers registering concerns. Appeals need to be locally heard in a timely and responsive manner.

In conclusion, Bill 173 gives the province unprecedented controls over long-term care, the scope of which we have not previously seen in this province's dealings with transfer payment agencies. Conversely, there has

historically been a relationship of mutual respect. Bill 173 eliminates this partnership and spirit of collaboration. Through Bill 173, the province is taking over municipal responsibility without any provincial-municipal negotiations. In addition, the bill is threatening the stability of community agencies and their voluntary funding resources.

I understood that seniors and their needs were to be the focus of the reformed long-term care system and were the individuals to be served through the introduction of this bill. If, however, this bill was intended to give the province and non-elected, unaccountable groups total control over long-term care services, then the objectives have been accomplished.

We urge you to seriously consider the real implications of Bill 173 and recommend amendments to this bill in this Legislature in order to recognize and build on existing municipal government structures and to ensure that seniors in Ontario get a system that is based on principles sensitive to their needs.

Thank you very much for your time. Ms Pitters and Mr Brillinger can answer any technical questions and I would be more than glad to deal with any governance issues.

In the interest of time I have about 20 recommended amendments that we'd like to put forward, and instead of going through them one by one now, if I can submit this to the committee for consideration.

The Acting Chair (Mr Dalton McGuinty): Thank you. I want to remind committee members that we are running approximately one half-hour late. We are to be on a bus bound for London at 2 o'clock this afternoon. If you want to allow yourselves some time to pack, collect your thoughts, perhaps make a phone call to a loved one and let them know you're still alive, we'll have to keep moving here. I'm going to cut off questioning on this at 11:55 and we're going to start with Mr Wilson. If one of the parties does not have an opportunity to ask a question, we'll simply begin with them in the next rotation.

Mr Jim Wilson: I will keep it short. I want to thank you for a very excellent and forceful brief, and I want you to just expand. I find it absolutely astounding that Metropolitan Toronto, being the largest provider of long-term care services in this province, was not consulted by this government. You stand by that statement and, having made it, what are your expectations from the government from this point on?

Mr Fotinos: I want to defer that to our assistant general manager for homes for the aged in terms of the discussions that she may have had. I personally have not been consulted and the political end of the municipality of Metropolitan Toronto has not been consulted. Discussions may have happened through the DHC with our homes for the aged division and I'd like to ask Ms Pitters to answer that question.

Ms Sandra Pitters: Officially, Metro Toronto has not been asked for a response to Bill 173. Unofficially, there have been several staff people who have served, including myself, on various committees of Metropolitan Toronto DHC. However, I want to stress that DHC staff have made it very clear that we are there as individuals

and we are to take our hats off at the table and not bring the perspective of our employing agencies or, in my case, municipality. So although I have participated as an individual, it has not been with the ability to express Metropolitan Toronto's position with respect to the bill.

Mr Jim Wilson: Thank you. That explains why perhaps there's so much wrong with the bill.

Mr O'Connor: One quick question, because this is alarming: The statements here are made that Metro was not consulted in this. I know that you run good long-term care throughout the community within Metro. It's very expensive, I understand, but lack of consultation—Mr Quirt, could you perhaps respond to that? Is there not some way that these people do get brought into the loop as far as consultation?

Mr Quirt: Yes. I'd like to say that the staff of Metro Toronto community services have been extremely helpful to us in program design activities on Bill 101 and are represented, if I remember correctly, on a number of our work groups developing policy for the multiservice agency.

Further to that, we've certainly had discussions with the Association of Municipalities of Ontario. I have gone a couple of times myself and presented, and I know my director of policy has gone and the special adviser on multiservice agencies has attended AMO. We're also talking with the staff of AMO now to develop a permanent liaison committee between the Association of Municipalities of Ontario and the long-term care division, so we'd meet on a regular basis to discuss issues.

1150

I would have to confirm that specifically the municipality of Metropolitan Toronto or any other municipality—we have not formally written to them and asked them for their comment on the bill itself, but certainly we've benefited from the advice of the staff and continue to do so.

Mrs Sullivan: I think it's extraordinary when the government is talking about community participation that it looks to the province-wide body for consultation on local issues. I just think it's madness.

I think this is a superb brief and many of the issues that you raise have certainly been on our minds. One of the areas that I want to particularly address in my question to you is the effect of now the DHCs' preliminary recommendation for 15 to 20 geopolitical agencies and the impact that that will have on fragmenting services which are now provided on a Metro-wide basis, some of them by you, some by organizations such as the Victorian Order of Nurses, Red Cross and others.

Mr Fotinos: I'll address it on a general level and then I'll allow Chris as well, because he's here for the grants that different agencies get and can speak perhaps on their behalf, and also Ms Pitters as well.

In talking to some of the agencies and some of the people who are going to be affected by the bill, they have expressed serious concern about the lack of choice on the part of the consumer. Currently, consumers have that choice with different agencies that are funded directly by Metro, whereas under the proposed system, especially

with respect to ethnoracial minorities, that choice, we fear, is going to be eliminated, and in many cases that ethnoracial barrier is what is an impediment to access to service right now.

Ms Pitters: I agree with Councillor Fotinos's remarks. I could also address the Metro-wide issue in addition to the individual agencies that are being rolled up into an MSA. We're in the particular dilemma of having, as you've identified, a lot of Metro-wide agencies that are being now fragmented potentially into MSAs.

We've met on a staff level with several of the Metro-wide service providers and there's indeed much concern about what's going to happen to service fragmentation and the fact that we believe there won't be the critical mass in the 15 to 20 MSAs to do the job well for some of those professional services.

So we're very concerned about the lack of any Metro-wide system that may result in increased costs and increased problems in accessing service and actually a decrease in quality because the practitioners will not be having the critical mass to maintain skills and competence.

Mrs Sullivan: In fact, service will decline.

Ms Pitters: Yes, that is our concern.

ASSOCIATION OF MUNICIPALITIES OF ONTARIO

The Acting Chair: The next presentation will be made on behalf of the Association of Municipalities of Ontario. I'd ask those representatives to come forward, please.

Mr Reg Whynott: My name is Reg Whynott and I'm here today in my capacity as a vice-president and the chairman of the health and social development committee of the Association of Municipalities of Ontario. Accompanying me are Ms Janice Mills, who is also on the committee and is the administrator of the John Noble Home in the city of Brantford, county of Brant, and Mr Phil Johnston, a member of our committee at AMO, commissioner of social services for the region of Waterloo.

We appreciate very much the opportunity to appear before the committee today to give you a position on some areas of concern that AMO has with Bill 173.

Although as an association we support the need for reform, and in fact have offered to meet government to government with the province of Ontario on a number of occasions now, we do have some concerns with some of the suggested processes in here and we will be expressing those to you in our presentation.

It's my intent, with your permission, to share my presentation with my two colleagues for two reasons: One is their expertise and experience, and the other is, I don't think you want to sit and listen to my voice for 20 minutes. I'd like to give you the opportunity to hear from a different perspective.

The Association of Municipalities of Ontario, on behalf of its member municipalities, numbering over 700 and representing approximately 95% of the population of this province, appreciates the opportunity to make our presentation to your standing committee on Bill 173.

Over the years, our association has monitored and commented on the reform and redirection of the long-term care system. Given the time constraints and the importance of the matter to our association, AMO has chosen to focus our submission today on the impact of the reform on the role and status of local governments in the new, proposed long-term care system.

On the subject of positions on governance, in responding to the government's various consultation papers and policy decisions on long-term care reform, our association has continually voiced its vexation with the province's disregard for the extensive municipal involvement in the long-term care system. As a result of this lack of acknowledgement, AMO has proposed on numerous occasions the need for an examination of provincial and municipal responsibilities in the long-term care system. To date, no formal examination or government-to-government discussions have taken place to address this issue, despite AMO's efforts. Our brief sets out AMO's concerns with the redirection initiatives and their implications on a continued municipal role in the long-term care system, in particular on the planning and service coordination functions.

In 1993, our association prepared a policy direction paper entitled *Municipal Option—Local Governance in Health and Social Services*. This document was prepared as a result of two major factors: Major provincial reforms were under way which would have significant impact on the municipal role in health and social services. These major systems reforms, which include long-term care, were not being addressed in a comprehensive framework and thus the overall impact on the municipal sector was not considered. Indeed, as part of these reforms, the province proposed the establishment or enhancement of responsibilities of local special-purpose bodies to assume planning, management and delivery responsibilities.

Municipal option was developed based on the belief that a fundamental restructuring of provincial-municipal responsibilities for health and social services will have a major impact on the future nature, focus and relevance of municipalities as local governing authorities.

Long-term care redirection is a major reform which has and will continue to have an impact on the municipal role in health and social services. As part of the reform, special-purpose bodies have been proposed to assume planning, management and delivery responsibilities.

Municipalities are a level of government committed to ensuring and improving the economic, environmental, social and public health of communities municipal councils represent. To fulfil this role in the future, the authority and scope of municipal government should be expanded and not fragmented among new local governing structures ie, special-purpose bodies. The relevance and effectiveness of municipalities in the future requires that as a level of government, municipalities are able to have input and involvement in the factors determining the quality of life and economic prosperity of their communities.

Municipalities are local governing corporations. New local authorities, as proposed in the reform of long-term care, will not improve the ability of municipal govern-

ments to meet the needs of their communities.

AMO has continually called on the province to work with the municipal sector to determine the appropriate local authority model for health and social services in their communities. Our association strongly believes that municipalities should ultimately make the decision in the local authority for health and social services. However, AMO believes that this can only occur if the province recognizes the values of the municipal role and agrees that the municipal option should be the first option.

1200

In late 1993, AMO responded to the Partnerships in Long-Term Care series through the development of a document, *Calling for a Municipal Option in Long-Term Care*. Although the province did not solicit comments on these documents, AMO felt a response was necessary given that the directions proposed raised numerous questions and grave concerns with the future role of municipalities in the long-term care system. The AMO document concentrated on two aspects of the reform: District health councils assuming the lead in planning for the long-term care system, and the establishment of multiservice agencies to assume the service coordination function.

Our association continues to have fundamental problems with some of the provincial government's decisions. These are decisions which, in our opinion, are resulting in a diminishing role for municipalities in long-term care programs and services, and it's our position that municipalities must share in the decision-making process on the issues which impact on their future role in the system.

AMO has argued and continues to argue that special-purpose bodies such as district health councils are neither financially nor politically accountable to municipal governments or the public they represent. Yet, DHCs have been delegated the responsibility of advising the provincial government on the allocation of funds and the planning of health and social services. In this advisory role, they have an impact on the setting of priorities for long-term care expenditures at the municipal level and, as an unelected, intermediate body between local governments and the province, they also represent a barrier to direct accountability.

The province has delegated to DHCs the responsibility of guiding the design of the local MSA models. This responsibility includes recommending to the minister the appropriate MSA structure which must be in accordance with provincial expectations and legislation. AMO is concerned that the province, through Bill 173, is attempting to enshrine the roles and responsibilities of DHCs within legislation without a formal review of their accomplishments and ability to assume new and expanded functions. Furthermore, DHCs will be responsible for determining the appropriateness of a municipal structure assuming the functions of a local MSA. DHCs have thus been empowered to decide the future municipal involvement in the reformed system.

In response to the partnership documents, AMO expressed its acceptance with the fact that DHCs have been given a role and mandate in reform beyond that given to municipalities, but noted that DHCs could not

meet the principles of the reform without a strong role and involvement of municipal governments. However, with every new decision made by the province, the role and involvement of the municipal sector, in our opinion, is being diminished.

Our association realizes that the Ministry of Health, in conjunction with the Association of District Health Councils of Ontario, has examined the roles and mandates of DHCs in the health system to determine what is necessary to achieve and support their expanded role. This review was not an open process in that it did not allow other stakeholder groups an opportunity to provide a critical assessment of the performance of the DHCs.

AMO calls on the province to conduct a formal, consultative review of the DHC's mandate and structure. I speak as a former member, in fact the former chairman, of a DHC which we thought was one of the best in this province and I think that review is overdue.

The next issue is multiservice agencies and I would like to ask Ms Janice Mills to bring some brief comments on that area.

Ms Janice Mills: It certainly is a concern of our association that the introduction and passage of Bill 173 will further remove responsibilities from the auspices of municipal governments. Rather than recognizing municipalities as a level of government, the Ministry of Health, in this piece of legislation, recognizes municipalities as only or yet another body in the myriad of agencies that are involved in the provision of long-term care programs and services.

As presented in the former presentation by Metro Toronto, municipalities have a long history in the funding, management and delivery of services and programs, which include the operation of homes for the aged and other housing for the elderly, the home care and integrated homemaker program, the administration of the Homemakers and Nurses Services Act, grants to voluntary organizations assisting the aged and certainly a large number of other programs. Many of our municipal homes—and I was pleased to hear the discussion about the setting up of the artificial barrier between the community and facility care because many of our municipal homes for the aged also integrate the provision of care in the home with the provision of other services such as Meals on Wheels, help lines, senior day care and specialized Alzheimer's day care, as well as a number of other issues and programs.

Mr Whynott: As argued in AMO's most recent document, Ontario Charter: A Proposed Bill of Rights for Local Government, municipalities are more than agents of service provision. They are essential to meet the needs, concerns and aspirations of the diversity of citizens who live in our communities. In terms of the lives that citizens lead and the concerns they have, local government is, to many, the most important level of government, with all respect, dealing with matters of direct and immediate concern and providing the most accessible and directly accountable political institutions. Bill 173 bypasses municipal councils as the representatives of local communities and instead moves towards introducing a new body to assume functions municipal governments are

sued to perform and have been performing in the past.

Our next section comes with great concern and I'll ask Mr Phil Johnston to comment.

Mr Phil Johnston: I won't be reading from the brief. I just want to suggest to you that since the onset of the reform, one of the features that has been particularly offensive to municipalities and to their dedicated elected officials and staff has been the refusal to acknowledge municipalities as an appropriate governance structure for the MSA.

I was impressed with the Metro presentation that preceded ours, but I did want to make the point that Metropolitan Toronto is an exception only by scale. All across the province of Ontario municipalities are heavily engaged in the provision of long-term care and have been for many, many years.

If I could use the municipality that employs me as a smaller example, we are now involved in the administration of some \$35 million of long-term care, employing 215 full-time and 200 part-time staff in direct services to the elderly and the disabled, programs that encompass home care and IHP, homes for the aged, Homemakers and Nurses Services Act, grants to home support agencies, the provision of Meals on Wheels and Alzheimer's day program and a seniors' day care program. Those are just some of our programs, there are others.

I'm here to probably restate, because it's been on the books for a very long time, not just with respect to long-term care but with a broad range of health and social services, the municipal position that the right of first refusal is a legitimate right of municipalities when it comes to providing community services. I've tried to indicate to you that as a level of government municipalities, particularly at an upper-tier level, have a proven commitment to the provision of long-term services and should indeed have that right of first refusal.

AMO would ask the province to delete subsection 11(3) of the draft legislation and to work with municipalities to establish criteria for determining local MSAs which respect the principle that existing local government structures should first be explored to serve as the MSA and that special-purpose bodies be used only as a last resort.

As an aside, I also want to note that municipalities currently provide a broad range of services, much of which is unfunded, but which will have to be funded in an MSA structure. I think, as an example in our own municipality, of the financial services expertise that is available to programs which is not fully funded; the human resources expertise that is available to our programs that is not fully funded; the legal counsel which is available in our municipality and which is not fully funded; and information systems which have been developed to service our programs which are not fully funded, in some cases not at all funded.

There is much to be lost, in my opinion, in a rejection of municipalities as the potential governance structure in the long-term care reform.

Mr Whynott: We have some very brief general comments on the legislation in a couple of particular

areas and I would ask Janice Mills to comment on decentralized decision-making.

1210

Ms Mills: In general, we have looked at the paradigm of rethinking government, which suggests that senior governments should focus on setting broad policies, legislation and standards for public programs, leaving the definition and implementation of local policies and delivery to local authorities and governments. In reforming this system, the province has expressed a desire to increase the flexibility and the responsiveness to individual and local needs and to attain community involvement in decision-making.

In other words, it appears as though the province is attempting to decentralize the decision-making process for the long-term care system and to reduce the provincial government's regulatory and supervisory involvement. However, in reviewing the draft legislation, the province continues to have an extensive role in the decision-making process which results in a more centralized system. However, the objective of the long-term care reform is to empower decision-making authority at the community level. The association does not believe that this objective of the government is being achieved with such a prescriptive piece of legislation.

Although I have no intention of reading it, I would like to use as an example subsection 52(2) of the draft legislation in referring to what, to ensure compliance with the act, a program supervisor can do. We have in the past dealt with program supervisors, but it has not been legislated to this extent and to this prescriptive nature.

Our association finds that this provision is very intrusive on the part of the ministry in the activities of our service providers. The association views this provision to be contrary to the intent of the legislation. It certainly can be argued as one reason for the overly prescriptive nature of the legislation the very fact that local MSAs will be unelected and unaccountable agencies and therefore requiring the watchful eye of a large central bureaucracy.

Furthermore, in section 56 of the legislation, a list of regulations which may be introduced by the Lieutenant Governor are set out. Approximately 42 of these issues, for which the details are uncertain at this time, will be addressed or are addressed in this section. It can be concluded from these regulatory requirements that local flexibility will be limited largely to the details and decisions on matters of lesser importance. Again, this appears to contradict the intent of the legislation which is aimed at achieving local flexibility through the development of MSAs which were intended to operate as separate and apart from our government.

Mr Whynott: I'll ask Mr Phil Johnston to comment very briefly on a couple of other areas: labour implications, mandatory services and the very vague section on exemption of MSAs.

Mr Johnston: The association has grave concerns around the significant and substantial problems and costs that are associated with the move to a direct service delivery system from the current brokerage system, which

is typical across Ontario. There are many questions that remain outstanding related to the staff and agencies that currently provide service to the clients, for example, under the home care program. There are collective agreements, employment contracts and agency contracts that represent legal commitments by municipalities which were formed on the basis of the current mandate of the municipalities. The association questions how and when the province intends to address and deal with these labour implications which will result from the implementation of the act.

I would note, for example, that the nature and extent of these difficulties are illustrated perhaps by the recent attempts at General Welfare Assistance Act and Family Benefits Act integration where we were dealing with only two labour unions largely and could not in fact resolve the difficulties that were apparent and not so apparent.

I'd also like to speak very briefly to the concern with the development of a list of mandatory services—the concern, of course, is not with providing services to seniors and the disabled; the concern is with the funding of those services—and simply to note that already in municipalities it's been made clear to us that both in the homes for the aged programs and in home care and other programs, funding restraints are in place and are continuing into the coming 1994-95 fiscal year. One is very concerned, of course, as a consequence of that, as to how additional services are to be funded when in fact current services are running into extreme difficulty at this time.

With regard to the four-year exemption on the MSA, the intent of this section raises a number of questions and concerns. As it states, the minister may relieve an MSA from providing some or all of the mandatory services and/or limiting the services purchased by an MSA. This exemption provision is extended for a maximum period of four years.

The implications of this provision are massive. Given that there is resistance by agencies to enter into an MSA structure, and that must be clear and understood by all, this provision would provide them with the opportunity to avoid integrating their services and assets. It is unclear what the decision-making process would be for implementing such a provision. Would it be based on a set of criteria, and, if so, what are these criteria? The association is uncertain as to the purpose and the intent of this section.

Mr Whynott: In conclusion, as the reform of the long-term care system proceeds, it is evident that despite their extensive experience in governing, managing and funding long-term care services, municipal governments will not be a part of the decision-making process in the reform system, nor has their role as a level of government been recognized by the province as it moves forward to implementing its decisions.

The arguments put forward in our brief, in short, contend that the reform will not achieve the following objectives: greater community empowerment, decentralized decision-making, integrated local programs and services, accountability, reduced government bureaucracy, or an efficient allocation of limited government resources. Note I stress it will not accomplish those. The bill must

be recast so that it recognizes and builds on existing local government structures which we contend can lead to achieving all of these objectives that you desire.

AMO's offer to consult government to government still stands. We are willing, we are interested, and we thank you for the opportunity to be with you today.

Mr Jackson: I find myself concurring with virtually everything that's been presented in this brief, but you have brought focus to some areas that are cause for some great concern when you juxtapose the fact that we're concentrating so much power in a non-elected, non-accountable body with a series of expectations without any funding commitment from the province.

That seems to be the nub of your concern. Your solution lies in the fact that you weren't consulted, nor are you part of the legislation, which would have provided the necessary safeguards to the merging of those two problems. Is that not correct?

Mr Whynott: That's correct.

Mr Jackson: I raised this question earlier, before you arrived. It was about the municipal social services review. The Ron Book commission is well known to Chairman Whynott and myself. When was the last time that AMO was, in that similar-type fashion, consulted about merging and reviewing the relationship between the provincial government and social and health services, which is what I understand the Book commission was about? When was the last time you felt you were being asked to participate at that level in these consultations?

Mr Whynott: Since I've been involved with AMO, we haven't been asked, but perhaps I could direct that to Mr Johnston, who has been around a little longer than I have.

Mr Johnston: I was a member of that particular review and I believe that's the last one that I'm familiar with.

1220

Mr Jackson: It simply died on the vine. We never did get an official government response from the previous government or this current government about that, but a considerable amount of work went into that and it dealt with some of these issues, as I recall.

Mr Johnston: Very much so.

Mr Jackson: In the interest of time, Mr Chairman, I'll yield because there are several additional groups yet to be heard from. But I thank the deputants for a very clearly enunciated brief and hope that the current AMO conference will bring even more attention to your concerns.

Mrs Haslam: I'd like to step back and take an overview of what you had and maybe focus on a couple of items. I see that you are raising concerns about "politically accountable to municipal governments," the MSAs financially and politically accountable to municipal governments, and again on page 5, municipal governments "suited to perform" the functions of an MSA.

I'd like to focus on people we seem to have forgotten over the last little while, and that is consumers. Consumers told us they wanted less fragmentation and more

accountability, more input and more hands-on in the long-term care that they were the consumers of. For instance, I know there's a seniors' group coming forward, and they're talking about consumers being fully involved at every stage of decision-making at the government level: district health councils, long-term care committees of DHC, consortiums, designing MSA proposals and the MSA, and in the planning of their own personal care.

That's what I like about what has been suggested, because we're drawing together a patchwork that's out there now of functions and agencies, over 1,000 agencies, drawing those together, making sure the facilities or the programs offered are consolidated and making sure that we're getting into local decisions, local representation on boards, local planning at the district health council with consumers on those boards, local accountability where they have someone to go to when they're looking at making a complaint—I would hazard a guess nobody comes to complain to a councillor when the Meals on Wheels isn't delivered on time—more consumer input, because they have an opportunity to take part and take control and work with the person on the plans that they have.

We're attempting to bring community-based governance structure to a long-term care system, and I wondered if you could tell how a council or a board would be able to refashion itself to become an MSA.

Mr Whynott: Not to be argumentative here today, I can suggest to you that if you wish to attend at a meeting of my region's health and social services committee, which meets twice a month, you'll find there's not a meeting goes by without a delegation from the organizations that you have just indicated.

We have a number of them who work very closely with us in the provision of services, and in fact we've changed the role of these people, as have many municipalities, to call them advisory groups, because we do want their participation and we've all learned the lesson over the years that consumers are very, very important. They're the people that many are neglecting.

Mrs Haslam: But I think that "advisory group" is the key. I think what consumers want is not to be an advisory group, but to be part of the board on an MSA.

Mr Whynott: With all respect, I would suggest that if I was sitting as chairman of a district health council and a delegation came before me, no matter what their issue was, I don't have to be concerned that that delegation can move me out of office on the district health council, but I certainly can if I sit on a municipal or a regional council.

Mr Jackson: You'll know all about that in the spring.

Mrs Haslam: No. I love these political things that come into committees.

Mr Whynott: I'm sorry. I'm just trying to answer your question.

Mrs Haslam: No, no, no. I just feel that more input is available either at a locally controlled district health council, at a local input on an MSA board, but more so there than they have an opportunity for under a municipally run situation where you would be an MSA.

The comments were that they don't want it to be a bureaucracy, that type of government; they want it to be in a more locally responsible way. I'm asking how you as your board would fashion yourself into that type of MSA.

Mr Whynott: In response to that, I guess what I'm saying is that we are doing that across the province in our municipalities and our regions. We are listening to the consumer. We are adapting our performance and our provision of service to the consumer. Rather than what we think we should be doing, we are asking for and getting direct input and information.

I can't speak for every municipality, but I know that's the process and the way we're going in most municipalities. Never have municipal governments or regional governments found it so necessary to listen to the public than they do today. More and more, as we state in our brief, the people of the community look to the municipal government as their government and their government of contact.

To take this away from the municipal governments that the people choose and to give it to an agency that someone on the outside appoints does not to me suggest accountability. It suggests you're removing the accountability and putting a buffer between the province and the people.

Mrs Haslam: I see accountability as having people on the board.

The Acting Chair: I'm sorry, our time has expired. Thank you very much for your presentation.

Mrs O'Neill: Mr Chairman, both times you've started with the Tories in the rotation of questions, and therefore I don't think that's quite fair.

The Acting Chair: We'll begin with the Liberals next time, Mrs O'Neill.

CANADIAN PENSIONERS CONCERNED, ONTARIO DIVISION

The Acting Chair: Our next presentation is made on behalf of Canadian Pensioners Concerned. Welcome.

Miss Mae Harman: We're appreciative of the opportunity to appear at these hearings and share with you some of our views on long-term care reform. My name is Mae Harman. I'm president of the Ontario division of Canadian Pensioners Concerned, and I'm one of 10 consumers on the north Toronto consortium which is planning a proposal for an MSA. I'm not here alone. A number of our board members are in the audience.

Canadian Pensioners Concerned advocates on behalf of seniors in regard to issues of concern such as medicare, old age security, taxation etc. We have a lively correspondence with government officials, develop position papers, send delegations, hold public forums, sit on advisory committees and issue a newsletter four times a year. As well as pressing for government action, we see education of both our members and the public as an important function. We also want to counteract some of the myths about seniors. We are affiliated with a number of other seniors' organizations that share mutual interests, and we network with organizations on an ad hoc basis.

We are a voluntary, non-profit organization composed

largely of seniors and funded primarily by membership fees and donations.

Most seniors welcome long-term care reform because we see it as an opportunity for less intrusive, more convenient, appropriate, quality care with greater opportunities to be involved in decision-making and with more choices available. The purposes of the act as set forth in part I are indeed commendable. They imply that consumers will be treated as persons of worth and dignity and that they will receive the right service at the right time in the right place and by the right care giver.

Does Bill 173 assure that these principles will be carried out?

As with most bills, much of the detail is left to the regulations. But decisions about such matters as eligibility criteria, fees for community services, hours of service, a framework for the complaints process etc are so vital as to require public debate. We join with some other groups in requesting that the major regulations be tabled at the time of third reading of the bill or prior to it so that there can be some public input.

Is the bill to be client-driven or budget-driven? Preconceptions that community care would be less costly than institutional care appear to have been gross misconceptions. Cuts in grants and staffing at the facility level, with resultant hardship to consumers, make us uneasy that community care may be unable to deliver all of its promises and that we will be faced with long waiting lists, difficult decisions about priorities and lack of care for many people who need it.

1230

Already people are falling through the cracks in the system. Like the reform of mental institutions years ago, cuts in hospital services were made before community services were in place. As the task group on transitional care has stated, people are now being discharged from hospitals sicker and quicker than ever before. This has led to unnecessary complications and general deterioration in health of senior patients, and in some cases premature death.

Another misconception about care in the home was that most people had family members who would carry the prime roles in care. Many people have no available family or significant others to help them. Many women, the traditional care givers, now work outside the home, either as a career choice or as an economic necessity.

Convalescent care on a short-term basis will always be a need. We fully support the following proposals of the task group on transitional care:

(1) Extend the mandate of the pilot quick response teams to include patients being discharged from acute care. Short-term enhanced in-home care to the level, if required, of hospital in the home must be available for seniors leaving hospital after surgery or major illness.

(2) Fund community in-home support service agencies so that they can include, where appropriate, evening and weekend shifts. In the week or two following any kind of acute care, current levels of in-home support can be grossly inadequate for those who are without an able-bodied, live-in family care giver.

(3) Increase the number of beds for transitional and convalescent-level care either within existing hospitals or in other care facilities as an alternative to the above.

In addition, family members who choose to care for people in their own homes on a long-term basis need recourse to respite care and financial compensation. This was dealt with in some detail this morning by the Alzheimer group.

Are consumers truly represented where decisions about long-term care reform are being made, and in large enough numbers to be more than tokens? Sometimes I find myself in the position of being the token little old lady consumer on committees and consultations. It is difficult in such circumstances to have much of an impact on others' thinking or on decision-making.

Are the people on committees really consumers who are users or have the potential to need long-term care? Are the consumers familiar with their communities and the needs of the people? Often in the past, boards and committees have sought out people who have had experience in providing service or people with political or financial clout instead of the people for whom the service is intended. There are many informed and articulate people in our communities who are receiving service or who have experienced the way services are provided whose assistance would be invaluable in reforming the system. The service is for the user. His and her involvement in planning is essential.

We have been searching for a definition of "consumer" that could meet the concerns just expressed and which could be incorporated in part II of the bill. Certainly, I think the family care giver belongs in the consumer area.

Consumers must be fully involved at every stage of decision-making: at the government level, district health councils, long-term care committees of DHC, consortiums designing MSA proposals and the MSAs, and in the planning of their own personal care. At least one half of the members of the above groups should be real consumers. Bill 173 does not specifically call for such representation on the MSA or on the DHC.

Canadian Pensioners Concerned has long maintained that since the reform is a bringing together of health and social services, social services should have equal representation at the DHC with health services. This ratio would be continued at all levels of planning.

Will there be real choices as to care, or have we oversold the idea of remaining in our own homes? Many seniors are saying that they prefer other options where the responsibilities of keeping up a home are taken on by others, where nursing care and other help in crises are available around the clock and meals are provided. Will we continue to encourage alternative forms of housing such as group homes, retirement homes, cooperative living, foster care?

What is going to happen to the other programs that our multiservice agencies such as settlement houses provide which fall outside the long-term care list; for example, educational, employment and cultural programs for all ages, and community development? Will these programs continue to be funded and developed? Communities have

much anxiety around this question. There is anxiety also about how volunteers will be viewed in the MSAs. Each MSA should have a full-time volunteer coordinator to recruit, train and support and cherish volunteers. There should be appropriate recognition of volunteer effort including reimbursement for out-of-pocket expenses.

Some programs such as Meals on Wheels are listed as services for which fees will be charged. No one must be denied service because of inability to pay that fee.

We applaud the inclusion of a bill of rights in Bill 173. We hope that it will be a means to ensure the consumer's rights to appropriate service, which affirms his or her worth and dignity.

Seniors are often afraid to raise questions, let alone complaints, about their care because this has often resulted in being labelled as difficult or hysterical, being neglected or being punished by restraints both physical and chemical.

A visiting nurse once told me that when she visits patients in their own homes, she goes as a guest. It is their own home and they are in charge of what takes place there. This is very different from the health care facility where the patient is dependent on other people and where other people are in charge of what happens.

Seniors look to long-term care for the independence to make their own decisions and for the sense and dignity and self-worth that such independence brings. Learning how to treat consumers as persons of worth and dignity must be fundamental to every care giver's training.

Nowhere in the bill is there a reference to wellness. The government's statement on health and wellbeing should have preceded all of the planning. We need to reject the old medical model based on sickness and put our emphasis on wellness and the prevention of illness. This will result in a healthier, happier, more productive population and will certainly save money in the long run. Social and recreational programs and programs which break down feelings of loneliness and isolation play important roles in prevention.

Assessment of need for care must be the responsibility of an interdisciplinary team which is sensitive to the needs of the whole person. It is the social worker who will be sensitive to the feelings of isolation and abandonment and to the problems of relationships with family, friends and neighbours. Other professions will have special skills about assessing hearing and sight problems and environmental and accessibility problems in the home. There should be easy access to a variety of professional resources as needed by the assessment team.

Personally, I would want my family doctor involved in any plans for my health care. He literally knows me inside and out and has earned my trust.

While we have raised many concerns about the implementation of long-term care, we do not wish to add to the doom and gloom which surrounds the bill in some communities. Reform of the system is sorely needed. Plans for the development of MSAs are moving forward constructively and confidently in some communities. The obstacles can be overcome if there is a will to do so. There are many concerned citizens and organizations who

are willing to work to make reform happen for the benefit of the consumer and in defence of the stated principles. It is too late to turn back. Let's get on with it.

1240

Mrs Sullivan: There are a couple of things I wanted to address, not the least of which is your concern—Mrs O'Neill wants to raise it as well—about representation of the consumer on the board. My sense is that the boards of MSAs will be made up of people who take out a membership in an MSA, and then they are the ones who will vote for the board. I suppose that we've seen takeovers in other areas and there could be a takeover in that area. But that's my understanding of how the boards will function and how people will be appointed to the boards, elected from within the membership of an MSA. Certainly that's the indication that we've had from Ministry of Health officials.

We're told that it's democratic, that it's representative of the community and so on, and I suppose that there would have to be, according to the ministry's criterion, people in certain categories who stand for office. I'll ask for a comment from the ministry after, but it looks as if we'll all have to get our \$5 out, doesn't it?

Miss Harman: You're a bit ahead of me because I've not heard of this concept of membership in the MSA or really how the committees will be elected.

Mrs Sullivan: Okay, then the other thing that I think you've pointed out that's very interesting that has been raised by a number of other groups is with respect to the linkages between the facility-based services and those which are in the community and, indeed, what appears to be almost a prejudice for the community-based services. You've raised some of the issues that may mean that, for some people, community-based service or service in the home, while it might be right in some ways, isn't necessarily the right service.

But that linkage between services that are provided from the hospital and those which are provided in the home—and I suggest the hospital in the home is the one that you raise—or through other long-term care facilities is problematical in this bill. One of the things that has been suggested is that the services that are offered by facilities be exempted from the 20% outside purchasing limit. I wonder what you think of that.

Miss Harman: The services which are offered by facilities?

Mrs Sullivan: Yes, which might be a hospital in the home or they might be adult day programs or respite care, which are offered now by hospitals or by homes for the aged or other facilities.

Miss Harman: I guess I'm not too keen on purchased services, if that can be avoided. I think in the interim that we're going to have to depend considerably on purchased services. I would like to see services either provided by the hospital or provided by the MSA.

Mrs Sullivan: How do you think they should link up?

Miss Harman: I think there has to be a close linkage. Whether that's done through the DHC—I expect it should be, because that's the group that has contact with the various levels of care—we've talked about a continuum

of care from prevention to dying, if you like, that those have to be very closely linked. I would agree with you that there's been some sense that everybody's occupying their own corner and that there hasn't been sufficient linkage. If the system's going to work, we have to be able to move back and forth, as necessary, from one kind of care to another.

Mrs Sullivan: I remember when your organization was formed. I think through the years you've had very pertinent briefs on most issues associated with health and other issues. I appreciate the input that you provide.

Mr Jackson: May I call you Mae?

Miss Harman: Sure.

Mr Jackson: Thank you.

Miss Harman: We correspond.

Mr Jackson: Yes, I know we do, and it's a great pleasure to meet you. Mae, I read your brief very quickly first, and then I wanted to listen to you carefully, because this must have been a rather difficult brief to write by virtue of the fact that everybody agrees we should reform long-term care. Everybody, allegedly, participated in some form of input or read documents as long ago as five or six years ago.

But fundamentally there was a significant shift that was caused, and that is not on the issue of one-stop shopping, because we all agree with that, and not that we should coordinate services, because that's still part of the bill, but it's on this fundamental point about who brokers these services.

We are getting considerable feedback from consumers who are concerned that some of the service providers that have been advocating for them up to this point would be lost to the system and moved into some sort of bureaucratic arrangement. A bureaucratic arrangement, by our definition, is one that is less accountable. You're dealing with a civil servant; you're no longer dealing with an independent VON nursing program, where they're advocating for your best interests.

Your brief expressed some concerns, but you didn't really address this notion of the fundamental shift of the brokerage model. You represent a consumer group. We're hearing this mixed message. We're hearing from the providers of the service, "How do you complain to the very agency that delivers the service?" which is the government MSA, or, even though it has its own board and there may be representation, there's no accountability of that board.

So we're starting to hear that one-stop shopping could end up being one-shop stopping, that it is your last chance to get a service, your fundamental right is the right to reject a certain treatment and that there's no real appellant mechanism that has any teeth, especially an appeal where people who are advocating for, in these cases, seniors get a chance to really get in there and roll up their sleeves and advocate.

So could you help me better understand that, because I think we agree on a lot of the things you've raised, but I'm trying to get a sense of your organization on this brokerage.

Miss Harman: Well, I think I'm much more optimis-

tic about the MSA than you are. I don't see it as a bureaucratic government organization; I hope it's going to be a community organization that will be so representative of the community that it is responsible. I'm optimistic that people will have an opportunity to say what kind of care they want, and if the money is available, that they'll get that kind of care. I'm very optimistic about the professional care givers who will function in the MSA.

Mr Jackson: I'll yield in the interest of time, Mr Chairman. Thank you very much.

Ms Margaret H. Harrington (Niagara Falls): I'd like to thank you, Ms Harman, for coming. I think you've brought a good dose of reality to our discussions today. I want to tell you that with regard to supportive housing, because I think that's got a key part in this as well, our government has increased the amount from \$50 million to, I believe, \$90 million. I think this will be a very good change in communities such as my own. In fact, Friday morning I went to a downtown church in Niagara Falls where they are now going to be building housing for the community, and they are negotiating with the various ministries over the next year as to what the support services should be for that downtown location to actually have a sense of community there that will respond to the actual needs of the people who will be there.

I want to point out and get your reaction also to what you've said on page 2, that many women are the traditional care givers. I think that is self-evident, that everyone should realize what the consequences of this are. I think probably yourself and myself and many other women across this nation have for many years worked to try to give more choices in their lives for women. If this is not done carefully, we are in fact taking away choices for women who have to be care givers. I think we have to be very careful around that point.

The Alzheimer Society raised this as well. They made two recommendations: first of all, that they ensure that care givers are on the boards of the MSA, and secondly, that day care programs are an essential part of this program. Would you agree with those two recommendations?

Miss Harman: Yes, I certainly would. I'm associated with some of the people who give direct care in homes and it's a very hard life. The economic implications are very great, because a lot of women have given up their jobs to look after a loved one and are left living on mother's old age pension or very limited incomes for the household and not being able to get on with their own lives or to get the kind of supports and helps that would make life more livable for them as well as for the patient.

1250

REGISTERED PRACTICAL NURSES
ASSOCIATION OF ONTARIO

The Acting Chair: Our next presentation will be made on behalf of the Registered Practical Nurses Association of Ontario.

Ms Verna Steffler: Being the last on the list and knowing that you're off to London, this presentation will certainly be brief. We don't want to see you speeding down the 401 and getting photographed.

My name is Verna Steffler and I'm the executive director of the Registered Practical Nurses Association of Ontario, which is RPNAO. We used to be known as registered nursing assistants and we used to be known as the Ontario Association of Registered Nursing Assistants. Also with me is Jan Hallett. She is the president-elect of the association.

Practical nurses work in a variety of long-term care settings and, increasingly, in home care. Bill 173 is therefore highly relevant to the members of our profession.

In making this submission, we want to underline how much RPNAO supports the overall objectives of this legislation. For us, Bill 173 is the centrepiece of the government's plans for overhauling Ontario's long-term care system. The critique and questions that follow are meant to be constructive, but our criticisms should not leave you in any doubt about where RPNAO stands. We would like to see a rapid passage and a rapid implementation of Bill 173. Ontario has waited a long time for this piece of legislation and we need to move forward on this.

In fact, before I get to our suggestions for improvement I want to explain how important certain aspects of this reform really are. Take the multiservice agencies, or MSAs. We see these new service delivery agencies as the single most significant aspect of the entire reform, yet in the media reporting on these proceedings, I've heard a lot of criticisms of MSAs—in fact, today as well.

For example, some groups say that they'll be too bureaucratic or that they'll be unable to attract volunteers. Usually, the critics don't explain why they have these fears; they just raise them as if they were inevitable. RPNAO disagrees with much of the criticism of MSAs that you've been hearing from other people. For example, we don't think MSAs are going to be overbureaucratic. On the contrary, we think MSAs will actually allow the system to operate with less bureaucracy than it does now. The truth is that MSAs have a lot of potential for redirecting resources. This will allow more of the dollars now spent on administration and overhead to go into direct care.

Here's the issue: Ontario's community long-term care system has thousands of agencies involved in service delivery. Some of these agencies offer a single type of service, some employ a single type of professional, but each one of these agencies, no matter how tiny, has an administrator or a supervisor or a director. Each one also has to pay for accounting, rent, heat, light and other overhead costs. Many have to support a board structure as well. All of this costs quite a lot. This fragmentation has produced duplication and gaps in service coverage and has made coordination very difficult. Even though many of these service agencies are very small and by no means flush with cash, too much of their operation revenue goes to administration and too little to the direct service.

Based on a study his firm did a number of years ago, Price Waterhouse consultant Neil Stuart estimated then that as much as 40% of home care spending in our system was going to administrative and overhead costs. Price Waterhouse is currently doing a further study of this issue for the Ontario Senior Citizens' Consumer

Alliance for Long-Term Care. I understand that it's showing essentially the same magnitude, even though the results are not yet final and some reanalysis is being done based on more accurate information.

But in a nutshell, the message is that too much is being spent on administration as a proportion of the overall budget.

By contrast, a system based on multiservice agencies promises big savings by consolidating administration and other aspects of overhead. In fact, with MSAs we think case management costs will decrease as well. Here's why: It's true that some people with complicated problems will always need case management even when MSAs are up and running, but at least sometimes case management is provided in our present system not because the case is complex but because the system is complex.

MSAs will help to simplify the system for case managers and consumers alike. The MSAs will make it much simpler for people who need to use the system. Having assessment and many different kinds of services available through one neighbourhood-based organization makes sense. It's far more convenient for clients, not to mention their families. One-stop access to a wide range of service providers means the individual only needs to deal with one organization, one set of rules and one integrated intake and assessment process. Convenience for consumers isn't the only reason to applaud this. The potential economic benefits are also significant.

At any rate, these are some of the reasons why we think MSAs will be much less bureaucratic than the current system, and because a system relying on MSAs will devote fewer resources overall to administration, there will be more funding available for the actual direct service. That's an important point for taxpayers and users of the system to consider.

Another issue raised by some critics is that a unionized workforce will be unresponsive to volunteer service delivery. We question why. If hospitals in Ontario are mainly staffed with unionized workers and yet our hospitals are famous for their volunteer programs, obviously there has to be some agreement with organized labour about what constitutes paid work versus unpaid work. But if hospitals have managed to clarify this, I can't see why MSAs can't either.

RPNAO thinks MSAs will be just as successful as hospitals, provided that they are willing to put resources into recruiting, training and supporting a volunteer program. As for the individual who wants to volunteer, we think the new system will pose no great obstacle. After all, volunteering to provide services to people isn't just motivated by an attraction to the agency's logo or its history and its traditions. Most volunteers simply want to help others, to make a meaningful contribution to their communities. That's what makes the difference, not whether the workforce is unionized and not whether the organization is new or well established.

One of the most contentious issues in Bill 173 is the 20% rule which will put a limit on how much outside service the MSA can purchase for its clientele as opposed to providing the service itself. This clause will make sure that MSAs fundamentally remain service delivery agen-

cies rather than brokers for other agency providers. This provision is a critical one and RPNAO fully supports it.

I'm going now to move on to discuss some specific issues and concerns that we have with Bill 173. I want to run through these fairly quickly in light of the time limits.

First, we want to raise some caution over the broad and sweeping nature of legislation and, in particular, our concern that so many critical issues are not spelled out but will be determined later through regulations.

For example, the bill doesn't even tell us how eligibility will be determined; that's left to the regs. Nor does it tell us what is mandatory with respect to service provision. Nor do we know how the question of user fees will really be handled, although we're glad to find that the bill does put some limits on what can be subject to a user fee.

Similarly, the actual mechanism for funding MSAs is not specified, even though we know that the ministry plans to introduce a regionalized system of envelope funding for long-term care. Although we support this move, we do have concerns about the system's capacity to cope with it. What happens if an MSA spends all its resources prior to the year end? Do they stop all services? Do they lay off staff? Will those in deficit be bailed out? What will happen to the clients?

1300

We also have two specific concerns about the provisions dealing with clients' rights with respect to their record. The first has to do with the right of clients to see their record. Although we understand the intention of this provision to rebalance the power between clients and providers, we're worried about its consequences. For example, we fear that employees may hesitate to make a chart notation or be tempted into double-charting because of fears that the information could be misunderstood by the client.

Another aspect of concern related to patients' records has to do with the provision allowing clients to request certain changes or corrections be made to the record. Again, we worry that making the record subject to client-initiated changes and corrections may create more problems than it actually solves.

With respect to service access, the bill permits waiting lists and stipulates timely response to client needs. However, the bill does not define what "timely" means, although it does say that regulations may be made to clarify how to determine the relative priority of people waiting for care. It seems to us that timeliness of response is an important indicator of an agency's performance, and one that can be of critical importance to the consumers. We would hope that any quality improvement process would include it as an indicator.

More generally, we wonder why the bill sets out provisions for inspection but is silent on any mechanisms for compliance apart from the liability of a \$5,000 fine for being convicted of an offense under the act. For example, regulations under the legislation could define a clear set of performance expectations including, for example, the obligation to measure client satisfaction and other process and outcome indicators. Would it not also

be a good idea to link excellence with some kind of monetary bonus? Money may be the root of all evil, but human beings do seem to respond well to positive as well as negative economic incentives. At the very least, we'd like to see a clause added to the list of potential regulations allowing these options.

We also have a concern about the bill of rights set out in section 3. Although we applaud this provision and recognize the importance of making sure that clients are informed of their rights, our real question is, how can respect for these rights actually be enforced?

A related issue for us is the appeals process. Although we were happy to see a time limit imposed on the board to communicate its decision quickly, we think such a highly centralized appeals process will clog up very quickly. Why not consider regionalizing appeals at, say, the district health council level, for example? That would really help facilitate speedy response.

We're also curious about provisions in the bill that would allow communities to have more than one MSA in operation. Are MSAs supposed to compete with one another for clients or is this provision merely to allow certain exceptions; for example, the possibility of permitting an additional MSA to operate, one that might specialize in serving a specific ethnic group? We had assumed that the ministry's overall intention was to give each MSA an exclusive jurisdiction with a given geographic boundary. The bill does not seem to make this very clear.

With respect to governance, we were rather surprised to find that the bill makes no specific mention of consumer participation. This is really curious given the strong leadership shown by consumer organizations in this province in helping to shape long-term care reform. We support the idea that employees cannot be board members of the organization that employs them and we agree that the ministry should consider board members' experience in health and social services in naming approved agencies. Still, we think more emphasis on consumer and family member participation on MSA boards should be reflected in the bill.

We were also somewhat disappointed to find that the role of primary care, and especially that of the role of the family doctor, has been completely ignored in the bill. As the lady previously said, they seem to know us all inside and out. Much has been written about the need for better communication and coordination between primary care providers and those working in long-term care, and yet the legislation makes no provision for these issues so important to continuity of care and client safety.

As our final concern, we want to draw your attention to the fact that this bill provides for a four-year transition period to move from the system we have now to the one envisioned in this legislation. Frankly, we think this is just too long and so we would urge members of the committee to consider cutting the transition period to no more than two years.

Ontario has already been waiting a very long time for this legislation. The \$647 million in additional funding was first promised four years ago. Today that money is worth less because of inflation; its purchasing power has

shrunk. That's one of the main reasons why waiting four more years strikes us as too long. But there's another.

We're worried that confidence in the long-term care reform will erode if things don't move along more quickly. Besides, we suspect a faster timetable could be managed. All across Canada health care systems are being transformed and restructured. In some cases the changes seem to be occurring almost overnight. Saskatchewan regionalized their entire health care system in the space of one year. New Brunswick regionalized their hospital system virtually overnight. Surely Ontario could put on a bit more speed. The sooner we move to implementing these changes, the sooner our citizens will reap the benefits.

I want to thank you all for your attention. If you have any questions, we'll answer them if we have the answers.

Mrs O'Neill: Thank you very much for your brief. I know you are front-line workers, and that's always helpful. You have a number of serious concerns, though, and then I have a little bit of trouble juxtaposing that with the speed with which you want to proceed. I feel that many of them have been brought forward. I think the one that's very close to our hearts and to yours is the funding issue. I would like to have the parliamentary assistant respond to your questions about funding, about the regionalized system of funding that's proposed and how this mechanism will actually work. Will there still be municipal participation in the funding? Will there not? How will the capping affect? Will there be staff layoffs if the budgeting isn't done well by the board? Those are very important questions. You've raised them.

Certainly, the people you represent, their jobs depend on them in some very important way. So perhaps the paragraph on funding could be responded to by the parliamentary assistant.

Mr Wessinger: I'll ask Mr Quirt to give a response to that question as set out in your brief.

Mr Quirt: The envelope funding system that we've consulted with DHCs about and have used to allocate our supportive housing planning targets—each DHC involves looking at factors like population and age in communities to determine, using those criteria, the fair share of available resources that a particular community might have to work with in long-term care. Soon we hope to be indicating to district health councils planning targets for the entire long-term care budget. We will be asking district health councils to give the minister recommendations on how the existing money and the new long-term care reform money should be spent in their community.

In other words, they'd take a look at that envelope and recommend to the minister that two new supportive housing programs should be started or one existing program for physically disabled people should be expanded and that there be, just for example, four MSAs and that the budget for them should be so much and so on.

You've raised the point about what happens if money runs out halfway through the year. Clearly, the plan is to allow local communities to plan on how a finite amount of resources is best spent in their community. In developing the contract between multiservice agencies and the

government we'd want to make sure that there were contingencies included there for fluctuations in service demand and so on. Our staff would be monitoring the budgets of those programs.

If in July it looked like there was a major problem, we'd be talking with the agency and saying, "Look, what are your plans to make sure that your services are allocated properly throughout the whole year?" Of course, we do that now: The majority of our programs have a finite budget and we certainly haven't had any of them shut down in December or January for lack of money. We hope to help them manage their resources for the period of the time that the funding is designed to cover.

Ms Harrington: Thank you very much for your presentation. I noted that on page 2 you made two very strong points, and that was that this system would actually save significantly on administration costs, and you reiterated that and emphasized that, and secondly, that the volunteer aspect is very important and that this legislation is concerned about that. We certainly want to encourage that and can see no reason why that wouldn't proceed. I thank you very much for making those points; I'm just sorry that Mr Jackson didn't hear them.

On page 4 you talk about consumer participation and I think that is important. I want to ask the parliamentary assistant the nature of consumer participation on the boards as he or the ministry would envisage it.

Mr Wessenger: It's certainly the intention to have consumer representation on the board, and we're interested in how to define "consumer." The way we anticipate that will be achieved is through the supervision we have with respect to the MSA's bylaws. In other words, we'll try to ensure that the form of bylaws that are developed will ensure that consumers are represented on the board.

Ms Harrington: Would it be fair to say that you can assure us and the presenter today that it wouldn't be just tokenism?

Mr Wessenger: Yes, definitely not tokenism. We said already a minimum of a third in our policy and certainly we're interested in—

Ms Harrington: I would ask our presenter to comment on that.

Ms Steffler: I guess my concern is how you define consumerism, because every one of us is a consumer. At some point in time, we are a consumer of the care. But we don't want to find that we end up with these MSA boards being made up of politicians, local representatives from local parliaments, governments, from the professions themselves, because then they become more of a bureaucracy and they are not paying attention to the people. If you're saying to me that one third of the MSA boards are going to be made up of consumers, I can go with that, but just make sure you define what is meant by a consumer.

Mr Wessenger: Thank you very much. I agree with you and we certainly agree with you that the consumer will be defined in a narrower concept to ensure that—

Ms Steffler: I think the idea, when you say a third, is much better than the lady previously saying about so

many times being the token one individual, which I certainly concur with. That's totally not appropriate, to put one person there and say, "Now you're going to represent the whole community as a consumer."

The Acting Chair: Thank you for your presentation. That concludes our hearings this morning. The committee stands adjourned until 6 o'clock this evening in London.

The committee recessed from 1313 to 1802 and resumed in the London Convention Centre, London.

The Chair: I'm not sure whether to say good evening or a late good afternoon, but we're delighted to be here in London, where we will be conducting hearings both this evening and tomorrow.

MED-CARE HEALTH SERVICES

The Chair: Without further ado, I would invite Mary Jo Dunlop, the vice-president of the Med-Care partnership, to come forward and give her presentation.

Ms Dunlop, we have a copy of your statement in front of us. Please go ahead. If I might just say at the outset, we have a very full agenda both tonight and tomorrow, so in most instances we will probably only be able to get to one questioner, but we want to make sure to hear all of your presentations.

Ms Mary Jo Dunlop: Thank you. Good evening. My name is Mary Jo Dunlop and I'm the vice-president and chief operating officer of Med-Care Health Services. Med-Care Health Services is currently the third-largest home health care company in Ontario and a provider of nursing and homemaking services to the Middlesex-London, Elgin-St Thomas and Oxford county home care programs.

While everyone supports changes in the health care system that are beneficial to the people in our community, Med-Care community health care providers believe there are many excellent features in the current local community-based services provided; that while the focus appears to involve disassembling and then reassembling community health services in another form, there is a sufficient existing base from which the minister, the district health council and the multiservice agency can realize the very valuable single access point; that we also believe there is always an opportunity to reduce fragmentation, as fragmentation is created as a result of the way in which program funding has to be utilized and has little to do with the attitudes of the gatekeepers of those funds or with the availability of services.

Service providers, whether individuals or companies, have been providing and continue to provide services in response to the needs of their community if their participation is allowed. Restricting providers outside the MSA will not guarantee service will be any more flexible or less fragmented. This legislation proposes an unnecessary transition from our existing community health framework to that proposed.

The need is for communication throughout the system, as clients and workers are remote and clients have increasing needs normally dictating more than one service. It is well acknowledged that the MSA will need to continue to form linkages with other providers of care outside the core services provided by the MSA.

Home care programs, agencies, individuals, community health physicians and hospitals and many more have consistently come together to successfully problem-solve on behalf of individuals requiring care. By virtue of the fact that our organizational and management styles are different, our combined ability to creatively problem-solve was enhanced. All the professional resources to form solutions for our community have always been available and the willingness of the parties has long been apparent. It is the lack of flexibility within the programs that has sometimes necessitated adding the support of other programs offered by other funded organizations or charities, or forced a burden on families, and it is that which has led to the frustration on the part of the consumer.

The multiservice agency and the district health council therefore have the opportunity now to eliminate some of the barriers to seamless service and need to be given the right to determine the best way of providing the required services to their communities, and by whatever method they feel best manages the intricate balance of funding and need. Their great continuing challenge will be to manage those limited resources where there is no limit on the need or the expectation of the consumer. Consumers have long voiced their disdain at the idea of waiting lists for services.

Educating employees of the multiservice agency through this transition to new program and funding guidelines, and having available knowledgeable staff at the single-access point, will be critical to the success of the reform and a challenge to those who undertake it. Information systems for education and the communication of information must be developed and in place once regulations are definite, in order for MSA staff to successfully accommodate the needs of the community.

For the hands-on care givers, educational requirements in community health professions must be finalized. Where there are thousands of homemakers who have willingly participated in level 2 upgrading within the last four years at the request of their employers, they now anxiously face another challenge in their uncertain future as they compete with graduates of yet another program for jobs. Current employers are trying to access funding for employee training, ascertain which program and, in the end, they're training their employee for the approved agency and not their own.

As professional as our employees are, they are affected by the stress they're experiencing. Community clients have already felt the impact of the change, just as patients in hospitals have, as they are cared for by workers who face an uncertain future. Some clients have had to endure a change in worker when some employees of commercial agencies fled to not-for-profit employers, hoping to find job security, only to realize later that there are no safe havens in community health. Relationship changes are always strenuous, but those between care giver and care recipient more so, as it is a very intimate relationship. Workers don't experience the job security of the past. Then they were in control. Their performance dictated not only their professional success, but their personal pride, and it also reflected the overall quality

and professionalism of the agency's service.

Each employee knew it was an earned privilege to be able to provide service to the community, and therefore, if every member of the group did their job well, they were working towards securing for themselves continued work in the community. Workers who have given up a great deal to return to college in midlife, often never having attended college before, to secure a future with their agency, are discouraged and frustrated.

Med-Care is a London company, started here 12 years ago by a nurse, Judy Bishop, whose love of community health and vision of its future contributed greatly to a very successful combination of quality service provision, a quality work environment and good business. Over 12 years, Med-Care has expanded to 10 Ontario cities, always maintaining its head office in London. In London alone, Med-Care employs over 350 nurses and homemakers and 35 office staff, with another 150 in neighbouring St Thomas and 90 in Woodstock.

Because the majority of service our company provides in London is to the clients of the home care program, most of these individuals depend on that business segment for their livelihood. Of these 625 employees, 95% are women, some the sole source of income for their family. They have chosen to work for Med-Care for a number of reasons, but one of the most appealing employment conditions is the conduciveness to family life.

1810

A usual employee is 35 years old, female, with one or more school-aged children. The ability to schedule her work hours in a flexible manner, which allows her to successfully combine continuing education, family and a professional career, is a much-sought-after feature, a feature she will be forced to forfeit working within an MSA. While there has been expressed a genuine concern for the employees who are currently working for the commercial agencies, it is unlikely that the system would be able to support the number of employees who are currently involved in service provision through commercial agencies.

Our nurses and homemakers and those of our competitors, both commercial and not-for-profit, have gained excellent reputations for the care they provide to the people of their communities. A strong contributing factor is the employee's or volunteer's association with an organization that has a clear vision, mission and philosophy, creating an organizational culture with which the employee or volunteer can identify.

Today, these people suffer from fear and frustration: fear because they don't know their part in the future or understand the future employer; frustration because they resent the upheaval. They are proud of their achievements within their own organizations and had future goals towards which they were working. They possess their own personal and professional goals they want to realize within their current organization. They see opportunities for advancement dwindle as they are absorbed, if they are absorbed, into a much larger agency. Many have expressed how truly heartbroken they are that this change is being forced upon them, and there are some who have already given up and left the field instead of facing the

future, and that is our loss. To destroy relationships only to attempt to recreate them in the future appears without purpose.

Med-Care strongly urges this committee to acknowledge the expertise of these home care programs, social service departments, long-term care facilities and community agencies that have very successfully served these communities in spite of the restrictions imposed upon them by the system.

This committee should be insisting that an MSA, as advised by the district health council, choose the most effective means of providing care for its community, that expenditures for direct care be monitored and evaluated and providers have an incentive to deliver cost-effective services.

We recommend provincial and/or national standards applying to all aspects of client services, as we believe this would guarantee quality and reassure the MSA and the taxpayers, ie, the people, that they can expect a certain level of service no matter who is the care delivery agent. This way, eliminating outside providers and direct employment is not necessary, nor is it desirable, because while the legislation appears to enhance flexibility and funding, it is actually reducing the number of options for creative provision of care.

Mr Ron Eddy (Brant-Haldimand): Thank you for your presentation. It's most informative and helpful. I note that you have several concerns about the legislation, and you've set those out and really stated that the new system won't really guarantee badly needed services that are presently in use, and also concerns about the employees.

Would you elaborate on how you feel about the new system compared to what we have now, with emphasis on: Would you rather proceed to improve what we've got now or would you rather take the MSA system that's proposed and have some of the safeguards built in that you've stressed in your presentation?

Ms Dunlop: I confirm I would rather that we take the expertise that's already established. I think that in the hearings you have heard a lot of horror stories. If we could ever measure what percentage those represent, I think you would find that it's very small. Personally, I've been involved for eight years in community health. I know that we have been forced to change and to adapt to the needs of the clients in the community and that generally it's gone very, very well. Why we have to disrupt that to create something new I don't know. I think that there's a tremendous base with the home care programs on which to build, and there are people who are absolutely willing to work together to do that.

So, in a very light term, we're throwing out the baby with the bathwater. We should build on what is existing, because there is a tremendous capacity for it to work.

Mr Eddy: Thank you for your explanation and for your service.

COUNTY OF LAMBTON

The Chair: I call on the county of Lambton representatives. Just so those who are here know the order, after the county of Lambton will be the Golden Years Advis-

ory Committee for Schizophrenia and then the Waiting With Concern Committee following.

Welcome to the committee. I'm glad that you could join us this evening. Once you're settled, if you would be good enough just to introduce yourselves and then please go ahead with your presentation.

Mr Jim Foubister: Thank you very much. Mr Beer, members of the standing committee on social development, this is with respect to Bill 173, An Act respecting Long-Term Care. I'd like to first introduce my colleagues and myself for this presentation.

My name is Jim Foubister. I'm chairman of the health and social services committee for the county of Lambton and I'm also an alderman in the city of Sarnia. Mrs Penny Phillips is here with us. She is the vice-chairman of the health and social services committee for the county of Lambton and is the mayor of Brooke township. Also with us, and who will be assisting me in the presentation, is Mrs Elizabeth Tenhoeve, a member of our health and social services committee for the county of Lambton, and Elizabeth is the mayor of Plympton township. Also with us, from a staff standpoint, is Mr Doug Hutton. Doug is our director of social services for the county of Lambton. Mrs Vicky Lucas is the acting administrator of Marshall Gowland Manor, Sarnia, Ontario, and Mrs Deborah Clarke is the acting assistant administrator for Lambton Meadowview Villa in Petrolia, Ontario.

Firstly, of course, we would like to take this opportunity to thank the committee for allowing the county of Lambton to make a presentation and express our concerns with respect to Bill 173. We in Lambton county certainly recognize reforming the health sector in long-term care is overdue and we have strong feelings on this issue. The care of our elderly is second to none in Ontario.

1820

We in Lambton county have recognized that care costs money and we have always strived to maximize those scarce resources. We have a long history, as do most counties in Ontario, evolving from the British workhouse of refuge. This history was initiated in Lambton in 1919, with Lambton Twilight Haven opening in 1936, Marshall Gowland Manor in 1968 and the North Lambton Rest Home in 1970, and we have numerous outreach programs within the county's structure.

Mrs Tenhoeve will be assisting me in presenting the brief. We have additional copies available for everybody, and we will try to answer any questions you might have at the conclusion.

Let me begin by applauding the government for recognizing and acting on the need for long-term care reform. We feel it is crucial to retain the inherent good qualities of our non-profit facilities and community services by affirming the county of Lambton's full support for the main principles driving redirection, which are the primacy of the individual and his or her right to a life of dignity, security and self-determination; the promotion of racial equality and respect for cultural and regional diversity; the importance of the family in the community; and equal access to all health services.

We believe that the county of Lambton is the proper

body to be responsible for ensuring the delivery of both community-based and institutional long-term care services for seniors in our area. We would do this in partnership with a local board of directors and with ministry support that provides clear leadership and performance standards.

We have brought with us, as I mentioned, copies of our presentation for your future reference and certainly would hope to be able to answer any questions you have.

We believe it is very important that your committee know something of the recent history of the county of Lambton's long-term care programs and services.

In the mid-1980s, a consultant's study was done for the county that recommended the sale of one of our homes for the aged, North Lambton Rest Home in Forest. When the results of the study were made public, council was somewhat surprised at the depth of feeling among county taxpayers that the ownership and operation of North Lambton Rest Home in Forest remain with the county of Lambton. The sale did not take place, and North Lambton Rest Home has subsequently had a \$1.6-million addition.

That event may have been the turning point—let me rephrase that. That event was the turning point that stimulated this council into being one of the most innovative, interested and capable in Ontario on seniors' issues and their care.

Consequently, in June 1993 we opened a new 125-bed facility in Petrolia, Lambton Meadowview Villa. This was a joint venture with the province at an estimated cost of \$16.4 million.

Our third county home is a 126-bed facility in the city of Sarnia which is presently awaiting a renovation upgrade. Marshall Gowland Manor was acquired by the county through Bill 35, which amalgamated the city of Sarnia's health and social services within the county structure.

Besides the three long-term care facilities, we also operate three community support programs: in Forest, a North Lambton outreach; in the city of Sarnia, a Marshall Gowland Manor outreach; and in Petrolia, a state-of-the-art Alzheimer day program.

As far back as 1988, prior to long-term care reform, a consultant's study recommended a central 1-800 number to meet Lambton county's community support needs. Still today we believe this would best utilize dollars available while at the same time meeting the community's needs for single access and eliminating the additional bureaucracy of a multiservice agency—in essence 911 for the seniors in Lambton county.

As we sit here today, we cannot emphasize too much the importance of the positive relationship between our council and the seniors in the county of Lambton. They have come to depend upon us to know their needs relating to high-quality programs and services. Further, the Lambton county community relies on us to act as facilitators and provide leadership in the delivery and implementation of health services.

I would now like to turn our presentation over to Elizabeth Tenhoeve, the mayor of Plimpton, to bring forth the points as we identify them within Bill 173.

Mrs Elizabeth Tenhoeve: Although there are many

areas of concern with this legislation, we will address only five major points. We'll begin with the purposes of the act.

First is "to promote the efficient management of human, financial and other resources involved in the delivery of community services." We question how efficient this new bureaucratic system will become without healthy competition which forces cost-effective administration and creativity in providing a quality service.

As an example, we draw your attention to what has happened to the acute care system in our hospitals over the years without healthy competition. We don't need to tell you we cannot afford the same thing to happen with community support services. Healthy competition is good. Free enterprise and freedom of choice is part of what our democratic society has been built upon.

A second purpose is "to encourage local community involvement in planning, coordinating, integrating, managing and delivering community services." It is difficult to determine from the act how you're encouraging community involvement in managing and delivering the service. Any reference to community and consumer input is vague and not clearly defined.

For example, the county is pleased that the ministry is identifying volunteers in the new regulations it's developing, but we have a concern as to what the new MSA as proposed by this legislation will do to the volunteer base already established in Lambton county's community service programs. The proposed MSA will take away a volunteer's choice to support their favourite non-profit agency and the people who operate it. Volunteers have repeatedly stated this fact.

As a second example, a centralized bureaucratic control which has the ability to assess a client's need, determine eligibility and also provide the service is not only considered a conflict of interest by us but is also unacceptably limiting a client's ability to purchase the goods and services judged appropriate by himself or herself.

As a third example, the appeals process established by this legislation appears to be the only resource for an unsatisfied MSA client. This process is likely to appear intimidating and daunting to the average senior. It will inevitably add considerable time, cost and stress to the overall effort to find appropriate services for a senior and family, who may be aggravated by the wait for a decision or, more importantly, may never see services because the window of opportunity may pass while awaiting an appeal decision.

In conclusion, while we support these purposes of the act, we feel that the legislation lacks substance to support these statements.

1830

For our second point, provincial control, regulations, while we agree with single and equal access for community-based services and we understand mechanisms will be put in place to ensure quality and efficiency through regulations, we are concerned that this draft legislation is leaving too much interpretation to the regulations, which have as yet not been written.

We fear this legislation may produce a highly bureaucratic, overregulated system for community health services that the province may not be able to afford. Bill 173 doesn't guarantee that better or more efficient community services will be provided than those presently in place.

We feel strongly that Lambton county has effective and efficient community services currently in place and caution the province not to throw the baby out with the bathwater. Rather, we'd like to see the legislation enhance good community services by reducing fragmentation and simplifying access to long-term care services. We do not feel this requires such sweeping changes as outlined in Bill 173.

Our third point concerns funding issues. Cost projections for this new improved health care system have not been made available to the public. It concerns us, following the experience with Bill 101, that the province may discover after the fact that we are unable to afford this community-based health care system. It is our experience that many community-based services are currently operating on a shoestring with contributions from user fees, volunteers, donations and individual fund-raising efforts as well as additional funding bodies such as United Way and municipalities. To make unilateral decisions for funding these programs without consultation with existing community agencies or their funding partners is jeopardizing continued support from these bodies. Our concern is that without these additional funds, this legislation may prove to be too expensive and less efficient.

Our fourth point is the MSA board composition. Multiservice agencies will have the power to assess taxpayers' needs, determine eligibility and then provide 80% of the services. The county of Lambton perceives this as a conflict of interest. In a democratic society, this bill, as presented, will be removing or limiting any choice alternatives available to the taxpayer. It appears that the only option for a client would be to appeal a decision to the ministry. Again we question, how many busy family members or seniors will be able to take the time or have the resources to challenge this cumbersome and threatening appeal process?

The MSA board composition is outlined but it fails to define the selection process for the board. The county of Lambton questions the accountability of the selection process of the MSA board which is to serve our taxpayers. The amendment in this legislation to the Ministry of Health Act identifies an appointment process to the district health council board. We find the statement in the legislation, "shall consider the importance of ensuring that the membership of the district health council reflects the diversity of the population in the council's geographic area," to be very vague, offering little assurance to the general public that they've been well represented.

There is only one way to assure accountability, and that's by utilizing the democratic process and ensuring a single board of directors, elected by voting members, as stated in your response from your paper Implementation and Program: Questions and Answers, Ministry of Health, June 6, 1994. We agree with this statement; however,

question who the voting members will be.

Secondly, may we point out this statement seems incongruent with the legislation, which states, "The minister may designate an approved agency as a multi-service agency for a specified geographic area." It concerns us greatly that a single agency becoming the MSA could create a bureaucratic monopoly which may be disastrous for community health services and too costly a burden for our taxpayers.

Mr Foubister: Our final point, Mr Beer and members of the committee, is, could you explain why municipalities and boards of health have been identified in the legislation as the last-resort choices to be the MSA when the infrastructure is already in place to provide geographically, furnished office locations, payroll and personnel functions, along with many other aspects of the MSA, throughout the whole county of Lambton?

We ask you to consider the major commitments of time, money and resources given to seniors throughout Ontario by municipalities. It seems illogical that the minister would consider the suitability of all other approved agencies before a municipality or a board of health.

We have five recommendations for the minister to consider:

(1) We ask you to reconsider your position that municipalities will be the agency of last choice to become the MSA. Lambton county already has the infrastructure in place, requiring only modifications to operate the MSA organization efficiently in our area. We recommend the minister address this specifically in the legislation.

(2) We recognize the MSA board composition is a concern for the ministry, as it is for Lambton county. The MSA board selection process needs to be specified in the legislation, as you have for district health councils. We recommend a blended board with representation from elected individuals, consumers and service providers. It should include individuals reflective of the community it serves in respect to its cultural, ethnic, linguistic and spiritual factors. We feel the county of Lambton is the most accountable body to ensure a blended board is elected by a democratic process and reflective of the public it serves.

(3) The legislation identifies that one agency can become the MSA. It is our opinion, in striving for a new culture, no existing agency has a community-reflective board which is truly accountable to the general population in Lambton county. We recommend the ministry strive for this new culture by legislating new community-reflective boards of directors, which will be accountable to the MSA and the community it serves.

(4) The minister's consultation process has been fast-tracked over the summer months. We feel that this is a poor time to be educating consumers, interest groups and the general public regarding the dramatic changes to the long-term care system. We recommend you extend the consultation process. During this extension of time, we would like to see service projections, cost expectations and efforts to identify and consult with other possible funding contributors. This information should be made

public and used to ensure this proposed system will be affordable.

1840

(5) Alternatively, a cost-effective, easily implemented approach to revise the long-term care system could be to activate a 1-800 single-access coordinating body. This body would ensure universal access, consumer input and could reduce duplication and fragmentation of services without total disruption of community support services.

Finally, we believe most emphatically that the county of Lambton is the most appropriate body to govern the delivery of high-quality term care to its seniors. This body has historically provided responsible control over budgeting and operations as a result of its direct responsibility to its local citizens.

County councillors, as elected representatives, are ultimately responsible to the taxpayers, and we must raise this money by putting our hands in the pockets of home owners in Lambton county. We must therefore have the ability to govern care and services delivered at a local level. Centralizing these controls at Queen's Park with a larger bureaucracy and its attendant lengthy and complicated appeals process is wrong. We do not have all the answers, but we have a history of partnership with senior government providing the seniors of Lambton county with a premium health care service.

Mr Chairman, we thank you and the committee members for your diligent consideration. We are sure that you will give these important matters, matters that will have a profound effect on the elderly of the province of Ontario for many years to come, your utmost attention. Believe me, we wish you well in your ongoing deliberations.

The Chair: Thank you very much for your submission. Just before turning the questioning over to Mr Jackson, as you were describing your homes, I was taken back I think four years just about now, when the extension on the North Lambton home was opened. I had the pleasure of being there and seeing it, and it was a lovely addition. I'm sure that it's been well serving the residents ever since. But I recall that day, which was very, very close to the end of the tenure of a certain government.

Mr Foubister: Yes.

The Chair: I enjoyed that. It gave me something to—
Interjections.

Mr Foubister: It's still serving the county residents very well.

The Chair: However, enough of that political talk.

Mr Jim Wilson: Put a plug in.

The Chair: It was an enjoyable day; we had fun.

Mr Jackson: I appreciate your brief. Your brief actually conveys in very clear terms a lot of concerns that were expressed by Metro Toronto and by AMO earlier today in Toronto.

My first question was going to be, when I listen to you I get the sense we really don't need this legislation. If the government simply set out a policy guideline giving you the challenge, you probably could come up with a version of an MSA which could be well managed by the county

services. However, that's too easy a question.

So I thought maybe what I'd do is pursue the notion of elected boards, because it's one of the five areas that you choose on and a theme that is gaining more concern at these public hearings is the elected nature or the lack of accountability and its spinoffs, which are the ability of individuals to complain to the actual agency that's serving them, which is a government agency. So either appeal or go to the Ombudsman, who'll tell you there's no way you can appeal it.

My question then has to do with, if you structured your MSA locally and you had a provision for people to get elected to those positions, how would you feel about that democratic process being overridden by any government which says, "In our opinion, a democratically elected board doesn't fit our criteria and therefore those democratically elected individuals cannot serve and we're going to put some other people in their place"? That provision exists in this legislation.

Mr Foubister: I guess in answer to your second question, I would sooner have the first one because it was much easier, you're right. I guess I would have to see the reasons behind why a government would take the position that an elected board would not properly serve the function. We feel that accountability is the largest part of that question and that is why we would promote the election of, if not all of the board, at least a situation that would probably be better than that which exists in the police service.

Mr Jackson: I couldn't agree with you more on that.

Mr Foubister: I would far sooner that there was much more election in that respect too, but we're not here to talk about that.

But if you would allow me to touch a bit on your first question, yes, we'd be ready, willing and able in Lambton county to attack that question of setting up an MSA of our own. We'd be more than willing.

The Chair: Thank you. I regret again that because of the number of presenters this evening—I know there are more questions—we'll have to end there. But we really appreciate your taking the time and coming down and making your presentation before the committee.

Mr Foubister: We thank you, Mr Chairman, and also all the members of the committee. Again, as I said, sincerely, we wish you well in your deliberations.

GOLDEN YEARS ADVISORY COMMITTEE FOR SCHIZOPHRENIA

The Chair: I call upon the Golden Years Advisory Committee for Schizophrenia. Welcome to the committee.

Mrs Martha Jean Noble: I'm Martha Jean Noble, chairperson of the Golden Years Advisory Committee for Schizophrenia. We're a small group, just four or five families, but we're all seniors. I'm also a family care giver. I want to thank the Honourable Charles Beer and board members for giving us the opportunity to express our needs as senior family care givers in chronic long-term mental disease.

What is schizophrenia? Schizophrenia is not a rare disease. As far back in history as 3000 BC, scholars have found descriptions of people with similar symptoms.

Schizophrenia is not generally accepted, not as the product of modern civilization, but one which has been with us throughout history. Schizophrenia is a very destructive illness, most common in young people between the ages of 14 and 28. It was not until neurology became interested in the higher functioning of the brain that real progress was made. Research has proven again and again that schizophrenia is a biochemical disorder in the brain.

As recently as 20 years ago, the diagnosis of schizophrenia often meant lengthy institutionalization. Due to this lengthy stay, many young people with this disease lost their individual independence, their ability to work, and some, at an early age, had their education ended. The disease schizophrenia is worse in some than in others. This horrible disease affects approximately 1% of the population, in every social class, in all countries. It is thought that about 30% have a remission and will function quite normally in the community. They will be employed, they will marry and have children and appear to contribute to society.

Of the remaining number, some will be helped by drug therapy, some will learn to cope. It is this category that we believe has the highest suicide rate. Statistics tell us that one in every 10 will commit suicide. Because their disease is more troublesome, they will not only need medication but will need financial support and individual housing for the rest of their lives. We know that in time the disease becomes less troublesome in some, but there is one in every 300 who is not as fortunate and these young people suffer from some form of brain damage. To quote Dr Barry Jones, director of the schizophrenia program, "We have an illness that was so devastating that we were forced to give medication that did harm." This was said at a Toronto news conference. Enclosed is a copy of that media release.

To have a chronically mentally ill loved one is indescribably painful. There is no illness that causes more distress or anguish than this horrible disease. The fact that the disease is chronic and there is no end to the delusions and hallucinations and the loss of judgement and loss of ability to plan and function in society places a very heavy burden on the family, both financially and emotionally.

People suffering from schizophrenia may have difficulty in knowing where reality ends and insanity begins. Many people suffering from this disease are highly intelligent, artistic and very sensitive, but they are often rejected by friends and neglected by exhausted relatives and shunned by society.

1850

Forty million families around the world know what it is to love a relative with schizophrenia. That's 40 million families, not people, and if each family consists of four members, then there are 160 million people caught up in the biological disaster known as schizophrenia. I've enclosed a pamphlet on that too.

In the late 1960s and early 1970s, the institutions for the mentally ill downsized. At that time, the hospital turned them away after a brief stay. These young people were too sick for group homes, and we were told that

with our daughter; she was not group home material. So she came home for maybe two weeks, went back to the hospital for about three months, came back home again, until we were utterly exhausted. That would be two weeks, night and day, you looked after her, and she went back again.

That was our horror story of the first introduction to schizophrenia. So when we say that the hospitals turned them away after a brief stay, these young people were too sick for group homes or independent living. They had no choice but to return home to their families, with little or no discharge planning. Many that didn't return home to families wandered the streets half-starving. Some froze to death. Many others were badly abused by society and the system. Due to unforeseen circumstances, some became involved with the law.

From the universities and colleges came some of our siblings, very ill and frightened, to share with mothers and fathers their desperate need for survival. After all these many years, our sons and daughters not only suffer from schizophrenia but are socially handicapped and emotionally deprived. I believe there is a press release there from Elizabeth Plummer from the Clarke Institute that states that.

Our home became their small institution where they felt safe and secure and tried to gain some control over their lives. However, the prison system has failed to recognize the crisis of these families who are now senior citizens. We will die on you soon. We must now make plans for when we will no longer be here to care for these now middle-aged siblings that have no home but ours, no in-home care unless we pay for it, very little social therapy and no tomorrow after we are gone unless the government will reward us for our many years of unpaid service by implementing immediate planning for individual assessments and supportive housing that meets the individual needs.

I want to impress upon this board the necessity of discharge planning and community follow-up. We must be the last generation to suffer the abuse of long-term neglect. We must take note of the abuse and hardship that is now apparent in senior families that have cared for sick siblings for many years. The majority of these families now suffer poor physical health and are facing the shortage of time.

We would also like to remind the government that we are special families. For many years we have given hope and around-the-clock nursing when needed. We have given love and encouragement on the better days. A vast number of families have given up many a holiday together and settled for separate vacations because of the lack of respite beds. The only alternative was to hospitalize them. We did that twice in 22 years, but it was so devastating for her that we never did it again.

Homes for special care receive a daily rate per person; also a \$3,000-a-year respite allowance. Why do the families not receive the same consideration? We need a maintenance allowance. We feel a maintenance allowance is long overdue. The need to remain a family unit is important for the wellbeing of the sibling, but the financial burden is overwhelming and impossible for some.

We have carried the burden of care with very little support from the government, and we must now speak of the special families that have given so much. We are the unpaid servants of the government. We are the families that face the stigma, the never-ending nursing care, the responsibility of providing supportive housing in our homes and also financial and spiritual guidance. We are the ever-present legal and trusted family that makes the successful link between the sibling and the doctor.

We know that an estimated two thirds of patients discharged from mental hospitals return to their families. In addition, there's an increasing number that rely only on their family physician, making an unknown number living at home with senior parents. The Ministry of Community and Social Services fact sheet enclosed is on a trust fund for people with disabilities. It's a fund for people with disabilities receiving family benefits effective August 1, 1993.

We are greatly impressed with the present modern inheritance trust of \$65,000 for disability-related items, but we are also deeply concerned that there is no reference as to the spiritual need of these disabled family members. At this time we would like to suggest that the church of our choice be approached for volunteers, approximately two persons per person, and the educational expenses become part of the inheritance package. It is our hope that the inheritance trust will become a spiritual and financial success, enabling a richer and more rewarding life for our siblings after we are gone. We will need the blessings of the church and the guidance of the government to achieve this goal. If we work as partners we will all have a better tomorrow.

The purpose of the Golden Years Advisory Committee for Schizophrenia is to establish the needs for siblings suffering from long-term mental disease, the needs being respite care, in-home care, socialization, supportive housing and individual care, spiritual guidance in the church of your choice and inheritance protection; to have schizophrenia removed from mental health to long-term care; to make the government aware of the families that care for siblings suffering from mental disease; to improve the wellbeing and lifestyle of siblings suffering from long-term mental disease—it's not by their choice that they have it and it is only by the grace of God that it's not one of your children; to bring to the government's attention the crisis that is facing the senior citizens who are running out of time, and therefore immediate planning is necessary.

Our objectives are to write letters and petition the government, the Ministry of Health or the Premier of Ontario to make them aware of the crisis faced by senior citizens caring for siblings suffering from schizophrenia. Public awareness: letters to editors, display booths, flyers, newsletters, radio interviews; to meet with district health councils or the Ministry of Health, community mental health and Grey-Bruce mental health. I might say at this board that that's been a very hard and trying time for us; very hard. The stigma in the rural areas is very pronounced. We want to have a pilot project to assess the benefit of in-home care, attendant care. We did that too and that proved to be very successful. We've paid for it

ourselves several times now. Instead of sending our daughter back to the hospital, we simply have a nursing agency come in and she provides the care that we need. I might say the last one was \$1,400 but they changed her drug to risperidone and it's been a big success. But we did not have to hospitalize her through that, and that was great for her and great for us too.

We want to work closely with council and non-profit housing to establish independent living with in-home care; to work with the government to change the system of inheritance distribution; to impress upon the government the need not only for the physical and mental care but the need for spiritual care in the future planning for our siblings.

Then I have a list here of the literature, and I won't take up your time, that I sent along to verify whatever I have given you.

The Chair: Thank you very much, Mrs Noble. If I recall, you also came down from Owen Sound the last time we were here, although that was a much colder and snowier night. So we're at least glad today has been an easier trip, we hope.

Mr Gary Malkowski (York East): Thank you for a very comprehensive presentation. It helps us understand the needs of people with schizophrenia in relation to home care and long-term care. But on the issue of respite care, the MSA will have specialized services for people. There'll be information and referral and resources available there, and there will be eligibility criteria for siblings or family members who need respite care.

Do you feel the criteria should be flexible enough to provide services for people who care for people with schizophrenia? I'd like to clarify what you mean by that, about being more flexible in the criteria.

Mrs Noble: I believe we should treat them as individuals. You know, when you graduate from high school you're not all going to be teachers or all engineers. You must remember they are individuals and so there's an individual need there. I think it's less expensive if the government will do an individual assessment, because some of these people require very little and others require more care, more attention.

We have a real fear that these people will be warehoused, and I want to leave with you a story today that I have not been able to verify but that I was told in confidence. A young girl phoned me up and she said her brother was in a group home, that a car pulled into the driveway and a young man got out with his suitcase and came to the door. When they opened the door, he came in and he said he was told to come there, that he would be staying there from now on, that his father had died and the other siblings had simply got rid of everything at the house, and so I guess they took the dog to the pound and they took him to a group home.

That really upset me. She did not want me to use her name because she was afraid it might be hard for her brother, but I think that already the crisis for senior citizens is happening. What do we do with them? We'd like to be part of the planning for them. They've been with us so long.

1900

The Chair: Mrs Noble, thank you for coming before the committee again, and in particular I would want to note a good number of articles and documents which you've included for all of us. We appreciate it.

Mrs O'Neill: Mr Chairman, can the ministry officials tell us how an MSA can get involved with the mental health component that our presenter, Ms Noble, has just brought forward? Apparently that's a possibility, but it is certainly not well known that it's a possibility because mental health, as we understand it, is outside the act. Could Mr Quirt or the parliamentary assistant give us an idea of how an MSA can get involved with mental health?

Mr Wessinger: I will ask Mr Quirt to indicate how the referral might work.

Mr Quirt: Certainly multiservice agencies could make referrals on behalf of families to community mental health programs. There is a mental health review under way within the Ministry of Health, and it's conceivable that if that review, through its consultation, were to suggest that more community-based mental health services like respite care should be made available, the multiservice agency for long-term care would be a building block for that, and that community mental health programs might augment the range of services that they provide. The bill would allow for that.

As it stands now, some people with schizophrenia and their families may have difficulty meeting the eligibility criteria now described in the bill for long-term care because, as you know, it's designed for younger people with physical disabilities and the elderly. But certainly if the reform of mental health results in more community service programs, if communities thought that was a good idea, there's nothing to stop an MSA from expanding the range of services to be in the community mental health support business as well.

WAITING WITH CONCERN COMMITTEE

The Chair: I call the representatives from the Waiting With Concern Committee. Welcome. You've waited until we were ready and we appreciate that.

Ms Deborah Jazey: My name is Deborah Jazey, and I'm the chairperson of the Waiting With Concern Committee. This is Mr Gary Jazey; Brian Dunne, who's associated with us through Participation House; and on the end, June Ellis, who is also a parent member of the Waiting With Concern Committee.

As far as our presentation, the Waiting With Concern Committee represents family care givers of adult children and consumers living at home. We are and have been the unpaid providers for our children for the last 20 to 30 years. The majority of our children have been on waiting lists for community services for anywhere from five to eight years. Our children do not qualify for attendant services as they require guidance and supervision, and they cannot fully participate in or direct their own care without this guidance and supervision.

Our group, the family care givers, are no longer able to support our children at home and your reform provides us with no light at the end of the tunnel. Relief and

respite are not viable options as it represents mere tokenism when our own physical and health issues make it impossible for us to continue to provide this physical support. We have other responsibilities and needs, those being to maintain our jobs, family income and careers. It's impossible for us to continue to provide the level of guidance and supervision once our adult child's school years have ended without putting all of our family members at risk. Our own aging and retirement plans make it impossible for us to carry it on.

Our children need to move on and experience the same quality of life and experiences as their peers and other siblings by living on their own. We continue to wait for community services, we continue to raise our voices, we continue to participate, consult and join committees, yet our children continue to be forgotten within long-term care reform. Our needs continue to be ignored. The concepts of equality or equity in service do not include them or us. We have been left out by the Ministry of Health.

When your reform of long-term care began in 1992, we were at the bottom of the deck. After two, almost three, years of our working within your reform process, looking at Bill 173 we simply see that the cards have been reshuffled. Our needs as care givers and parents and the needs of our children have been relocated and reassessed yet we still have ended up on the bottom of the deck with increased vulnerability and at risk of being totally lost in the hand that Bill 173 is dealing.

We still have no guarantees; no one is willing to guarantee to work towards ensuring that our adult children will not end up institutionalized. This bill has not addressed the rights of those people with high care needs to service in the community, nor has it addressed how finite service dollars will be equitably disbursed to the wide variety of individuals who need service in the community. This bill has left us without answers, commitment and direction and a vision of the future regarding people with high care needs. This bill has left us without true reform and has given us bureaucratic juggling and rearrangements that bring us no closer to obtaining service for all in the community today.

Time is slipping away and so is our ability to cope. Our needs continue to be ignored and the Ministry of Health continues not to understand these needs, because in understanding our issues would lie the responsibility to address these issues and make commitments to the needs of our adult children and to us as primary care givers.

It is important for you to hear about our group's experience with long-term care reform. It is our feeling that our experience with long-term care reform will reflect on Bill 173 and its implementation.

Our experience will also give you the base to understand our concerns and mistrust regarding this piece of legislation, its implementation and its failure to include those with multiple disabilities who may not be able to direct their own care.

We have been meeting since 1991. We began by talking to the ministry office. We spoke to planners of the district health councils, with meeting after meeting trying to get Health people to understand the needs of our

healthy, adult children with disabilities.

We were told to prepare a proposal. After much hard work, effort and countless hours of preparation, we consulted with Health representatives. They told us our proposal was right on the mark, it was wonderful, but that we would have to wait. We waited to find out where and when it was to be sent, never getting clear directions from those who were supposed to guide us through the process. Phone calls made to these officials would often go unanswered. Again we were told to wait.

It was determined that even though we were put on hold, others were obtaining funding.

We presented a model of support that would best provide the guidance and support required by those people that we represent. We were told it couldn't be utilized because it doesn't involve supportive housing. Our model is cheaper. What happened to consultation and listening to the local community and consumers? It appears everything is being overridden by arbitrary policies. From where and to what end? Again, our model is cheaper to the taxpayer but it is ignored. Why? Subsidized housing costs the Ministry of Housing upwards of \$800 to \$1,000 per unit per month. A unit represents one bed. Why did you ask us as parents and our committee to spend our time if the answers were to be dictated?

We have joined subcommittees of the district health councils to talk about the needs of our children, and end up in the middle of discussions that continue to focus on the system, the bureaucracy and professional issues. We participate time and time again in consultation after consultation—the red book, the green book, the blue book—but our voice and the voice of the individual that we represent goes unheard. Again, we are not in Bill 173.

In 1991 we started out requiring immediate support for 17 people. In 1994 we continue to need support for 17 people. Bill 173 does not help us to access support for our children.

We cannot go on and we cannot accept that our adult children with physical disabilities should end up in institutions or in community services that do not provide the support and supervision that they require. By ignoring our needs in the consultation process, by the Ministry of Health officials telling us it's important to get more bang for the buck, by the ministry's lack of commitment to meet or even acknowledge the needs of those with high care needs, your inference within Health is that we as parents have wasted 20 to 30 years of our lives supporting children at home as you will make no assurances that they will not be institutionalized as adults.

All of us were told 20 years ago to keep our children at home, to teach them to be as independent as possible and that when we as parents could no longer continue to support them or when the child became an adult and wanted to live as independently as possible, there would be something for them. Unfortunately, we found out the hard way there's nothing.

One of the parents on our committee was allowed to adopt her son with multiple disabilities 16 years ago with the provision that this child had somewhere other than an institution to go when it was time for him to live inde-

pendently. Ministry officials at that time guaranteed this. Where are the guarantees now for these people?

1910

We as parents and care givers feel betrayed. I raised my son for almost 21 years and have not asked for anything from the ministry. It was I that paid the \$36,000 for the custom van. It was I that paid for the modifications that were required to our home to make my son as independent as possible; the countless hours of lifting and just doing all of the responsibilities. The sacrifices are worth it, though, because we had a light at the end of the tunnel. We had a promise of service being provided to our children that would accommodate their disabilities yet allow them to grow and live as independently as possible.

Now we're being told that the people in institutions have priority to service in the community, as it cost them nothing to have us as parents, care givers, provide these services for free. Did we make a mistake not institutionalizing our children then? What happened to all the rhetoric regarding normalization and integration?

This legislation continues to focus on the bureaucratic process and procedures. It continues to focus on the needs of and the creation of a system which provides great opportunity for buck-passing and a process of accountability that is so cumbersome it is unusable and time-consuming to the general public, and to us as care givers who have already been tied to our homes, we cannot leave our 19-, 20- and 25-year-old adult children to go out now. How can we participate in the process? Where is the time, who is responsible and how do we get off the waiting list?

This bill proposes a planning process through district health councils, but we have no true local power, direction or accountability. Edicts regarding subsidized housing, emergency response come from on high and are imposed locally. Those of the old power service systems are those who are appointed again to the councils under the categories of providers and others. Look at the makeup of the health councils the next time you have access to them. How many true consumers are really involved in this system? These councils have no accountability to their local committees as they are appointed, not elected. The council does not have a voting membership. All can apply but only a select few are chosen. We as consumers are not afforded the opportunity to select our representatives.

This bill provides us with no local control. This process just keeps us in the service system doing busy work. When and where will the focus be on the individual and the individual's needs? This process continues not only to ignore these direct and functional needs, but in fact uses up greater amounts of service providers' time, energy and money that could be going to provide services to meet the basic needs of individuals.

How does the consultation process work? What is determined? Who and what is listened to and what is ignored? What are the criteria for using information gathered in all these consultations? Is it just another way for the government to avoid taking responsibility and not having to make strong commitments and value-based ethical decisions regarding people's right to live in their

own community regardless of their level of disability?

In summary, during the latter part of 1992 and early 1993, we, as parents and family members of individuals on the waiting list of Participation House Support Services, began to meet with various ministry representatives and health representatives to state our concerns and elicit their assistance in respect of certain concerns. These concerns are in respect of:

First, the exclusion of this group, which is individuals with physical disabilities who may not be able to direct their own care, from the long-term care reform.

Second, the implied reference was another concern that we had within the long-term care document that adult children would or should remain at home for 40 or 50 years. I can assure you that this information has dramatic impact on aging parents, their children and would greatly influence the decision of young families caring for physically disabled children today. The concept of long-term care within parents' homes directly contradicts what we as parents heard from the ministry and the services for years regarding independent living, normalized principles and full integration.

Third is the fact that no additional expansion of services has taken place within the London community for this identified group since the original and one-time startup allocation to Participation House Support Services, London, in 1989. The waiting list continues to expand and is currently at 92.

We have been contacted by members of the parents' group at the Thames Valley Children's Centre to determine how they can get their pre-teen and younger children on the list. Questions regarding equity of service to all people within long-term care arise given these practices.

Bill 173 does not provide for 24-hour support for people with multiple disabilities and who have been on waiting lists for years currently living at home whose parents can no longer provide for them. We need a guarantee for service for those who may not be able to direct their own care. Bill 173 does not provide us with a commitment that young adults with multiple disabilities will not be institutionalized against their will when families can no longer provide the support required. This includes nursing homes. When we talk about respite, we're told, "Well, they can go to the Dearmess Home." I don't think so. We need a commitment that the community will support them. Bill 173 does not provide a guarantee of equal access to service for all in the community, regardless of an individual's disability.

We need this bill to define a set of basic needs and entitlements. Bill 173 does not provide a guarantee that access to service will be equitable for those living at home. Did we do the right thing by supporting our children for the last 20 and 30 years, only to find out that those in institutions have access to the services in priority to those still at home? We need this guarantee.

The ministry and this bill need a focus to ensure that dollars go to support people directly and are not lost in supporting systems and bureaucracies. Reform should be focusing on how to get more dollars to the individuals

and needs, not on how to get more management and meetings. The ministry needs to select agencies that spend most of their government dollars on direct, front-line care, to lead this reform process.

Most importantly, do not ignore the models that are less costly overall, nor the choice of the individuals. Individuals should not be forced into cooperative housing and subsidized housing when judging efficient use of tax dollars. The long-term care office and planning body should consider costs to both the long-term division and costs to the Ministry of Housing; and lastly, meet the needs of those in need now. The current process only ensures that we will have to wait on the bureaucrats, planners and professionals to rearrange their seating. This bill should address these immediate needs.

In closing, your bill continues to be a disappointment to us. The real reform, the move to support all individuals within the community with the individualized funding to meet their basic needs regardless of disability, is not guaranteed to those on waiting lists. Our children are left out and we are left in crisis.

Is it possible that Health does not understand our community needs? As we stated in the beginning, you have recreated, relocated and reassessed, and we still have the same results: 17 in need of immediate support in 1991 and 17 people in need of immediate support in 1994. These reforms have had and continue to have little focus on results that will directly impact upon the individual in need of service. You have spent three years and you've had us invest three years of our time, time that we could ill afford, and unfortunately, the results are still the same. The deck has been reshuffled, but we still come out on the bottom: no service, no guarantee for community service and we're still on a waiting list.

I want to thank the committee for allowing us to present this presentation.

Mrs O'Neill: Thank you, Ms Jazey, for coming. I am rather moved by your passionate presentation, and certainly, the presenter before you.

It seems most unfortunate that parents like yourselves have not been more meaningfully involved, and I use those words carefully. I don't know your program and for that I apologize. I am wondering if the plan was something like special services at home. I'm trying to appreciate your brief. Is it that you need more supports within the home? You talk about it being cost-effective and that program has been cost-effective and yet I think it is also outside this bill. So perhaps you can help the committee by just explaining what the need is or why you feel you've been left outside the bill.

I think you've been very clear in saying that the particular children you're here representing tonight, your own children, do not fall into the direct funding for attendant care, for instance, but they are much beyond that. So if you could just help us by saying why you think they fell out or how they fall out, because I'm just not able to put that together.

Ms Jazey: Basically, what the bill provides for is attendant services.

Mrs O'Neill: Right.

Ms Jazey: Our children do not qualify for attendant services. One of the criteria for attendant services is that people must be able to direct their own care. Our physically challenged adult children in some cases appear—I hate to use this word, but normal—but they cannot direct their own care in some areas. In some areas they can; in other areas they cannot, such as money.

My son is 20. You can give him a \$20 bill. He can take a cab. They can tell him it's \$5. He doesn't know how much change he's getting back. So you can see, they are very vulnerable that way.

Now, what has happened with this group—and we are associated with Participation House. Participation House provides support to adults outside of their home. It gives them an independent living area, with 24-hour service, if required. It's their own home; they're not in an institution. They don't have to say to anyone, "What are we having for dinner tonight?" It's their choice. It allows them to live independently, away from their parents.

1920

Mrs O'Neill: You say it doesn't fall into supportive housing either, though.

Ms Jazey: Not really.

Mrs O'Neill: It's something in between?

Ms Jazey: Yes.

Mrs O'Neill: The ministry officials might try to help to see whether there is any provision in this bill that would perhaps be of some use to a group such as this.

Mr Jackson: It's like Cheshire Homes, isn't it?

Ms Jazey: No. At Cheshire Homes you have to be able to direct your own care.

Mr Wessinger: I'd like the ministry staff, first of all, to indicate whether this program at Participation House is under Ministry of Health jurisdiction or not—it is?—and if there are other similar programs and if they would come under an MSA jurisdiction.

Mr Quirt: If I understood the presentation correctly, I think what the presenters were asking for is a form of supportive housing where a degree of supervision is provided so that those people who aren't capable of living independently and calling for help when they need it could be monitored so they would live with the same degree of supports that people in supportive housing have, but wouldn't necessarily have to be able to know when they needed help and to summon it. We'd be prepared, as the long-term care division, to consider a proposal that involved that degree of supervision in a supportive housing setting.

I know our consultation paper on supportive housing out now is aimed more at those situations where people live independently in their own apartment and have 24-hour, onsite staff. If they fall they press a button or call out and somebody is there in a couple of minutes to help them.

If I understand your presentation correctly, what you're looking for is a community living alternative for those people who might not be able to summon their own help and would need a degree of supervision above that.

Ms Jazey: That's correct.

Mr Quirt: I'm speculating here, but it wouldn't surprise me if some of the children that you're caring for would, from a bureaucratic point of view, be called dual diagnosed. Perhaps you may have been talking to the Ministry of Community and Social Services as well about support services from there. Here again, our local office would be happy to consider working with the Ministry of Community and Social Services on some kind of a joint arrangement. Again, we'd be obliged, of course, to take the advice of the district health council into account in that regard. I hope, if you haven't made it clear to them what type of program you think your children need, you will. I know our staff would help you do that.

If we haven't been as supportive as we might have been, from your perspective, to date, I agree that it's taking time for us to flow the money for supportive housing and to get new programs started, but I know we're piloting a fairly intensive respite program here in London over the next two years to look at providing respite for families in your situation, where an intensive weekend relief will be provided for some families.

I know that in discussions about the redevelopment of a chronic hospital here there's discussion about the creation of supportive housing spaces funded from the hospital budget that's being redeveloped for high-care individuals in the community. It wouldn't surprise me that it might be possible to link the needs of the people you're representing to either of those two processes.

Mr Brian Dunne: Perhaps I could clarify the Participation House Support Services service. It originated in the Ministry of Community and Social Services and is currently funded through the Developmental Services Act and the Homes for Retarded Persons Act, administered through the long-term care office. Under those pieces of legislation, it takes its mandate and direction.

Mr Quirt: That's correct. When the long-term care division was established, there was a discussion about whether those programs and services that serve people who are both physically disabled and people who had also a developmental disability should stay with the Ministry of Community and Social Services in the programs for developmentally handicapped people or move over. There were some that did and some that didn't, dependent on local negotiations and discussions. Here again, we will do our best to make sure that the needs of your folks don't fall through the cracks because of two ministries being involved in support services in the community.

Mr Dunne: But the issue really is that, for people with high-care needs, attendant services are capped for the number of hours of support a person can get in the day. This group of people require 24-hour support and we can't find that in this piece of legislation.

Mr Quirt: This piece of legislation will fund supportive housing programs with 24-hour support and will fund support services to the extent that people who are ventilator dependent will live independently in their own apartment, so there's no restriction in this bill that would limit the degree of services available in supportive housing. Clearly, a number of our supportive housing clients have lived their lives up until they moved to

supportive housing in chronic hospitals.

The Chair: I'm sorry that I'm going to have to end the presentation, but I think this has been very useful in focusing on a particular group of individuals. Having some knowledge of Participation House and the excellent work that you do, this has been very valuable for the committee in better understanding those problems that you've set forward, and we thank you very much.

LONDON REGIONAL
PSYCHOLOGICAL ASSOCIATION

The Chair: I call the representatives from the London Regional Psychological Association. Welcome.

Dr Edward Helmes: The London Regional Psychological Association is a fraternal group. Any given year we have between 80 and 100 members and we deal with a variety of individuals with disabilities and with disabilities related to aging, both in the community and in a variety of institutions.

The process of reform has introduced many changes to the care system, both within institutions and coming up to the community agencies. In many cases, any process of change is stressful for those involved, but in many cases this stress can be ameliorated by deliberate attempts made to moderate the effects.

A process of this sort is one in which the individuals in the agencies and the facilities have very little control over what happens to them, and if a process that involves effective communication is set up, if there are pilot projects conducted that indicate better ways to go through the entire process, then this knowledge can be passed along to individuals later in the process who can then benefit from the learning process. This hasn't been done with the legislation that was introduced under the 1993 bill, Bill 101, and it doesn't look like it's going to happen with Bill 173 either.

This means that life is going to be made much more difficult for the staff of these agencies, which in turn carries over to having a deleterious effect on the people they care for. There's an inevitable increase in sick time, which means that less staff, less familiar with the people receiving care, have to take over, increased use of employee assistance programs, increased staff turnover. It would be nice to see some kind of arrangements made to produce a more smoothly integrated process of change into the whole process.

Secondly, we're rather pleased that the physically disabled individuals are going to be covered under this legislation and that there will be more possibilities for independent life for them in the community. At the same time, and I think echoing other presentations, we'd really like to see other individuals given the same kinds of opportunities; people with serious psychological disorders, people with developmental disorders and also the individuals with acquired disabilities.

1930

The folks who have traumatic brain injuries aren't really covered under this legislation and, while there are noises about improvements being made for some of these groups, that doesn't seem to have had any immediate effect. So we're hoping that, at some point, better ser-

vices will be available in the community for more disabled individuals.

Another point deals with the transformation of placement coordination into part of the multiservice agencies that are being set up. Reading the planned legislation, there seem to be some good things in there but it's not entirely clear exactly how or what guidelines are going to be set up for individuals making decisions about placement, or about what services are going to be provided for particular individuals applying for them.

It would be very nice to have somebody who's quite knowledgeable about the whole system and is quite well trained in making these decisions and who has access to knowledgeable advice on the relevant issues. It would be very nice to have a system like that set up and it's not clear that the one the legislation is planning for will in fact do that.

A critical part of all of this is that the individuals who are requesting placement in some kind of facility have a degree of choice about where they go. It's not clear that this is in fact going to happen, nor is it clear whether any of the facilities have any say about who they are going to be receiving.

Another concern we have is related to the confidentiality of information. The bill does say that the records of providers are to be confidential, but it also sets up provisions for program supervisors, who have relatively free access to virtually every kind of record in the system. Many of the regulated health professions that will be involved in providing care for these people have the regulations under their own legislation pertaining to the confidentiality of records, and it would seem that there is a built-in conflict being set up here between the program supervisors having access to whatever they want and the providers having a similar restriction on not releasing information. Unless this is sorted out in the legislation, we're setting up a guaranteed system for conflict in the future.

Sooner or later, we will be getting around to the role of psychologists in this legislation and we're rather disappointed that we continue to be left out. One of the important features we think is implicit in this legislation is that before an individual gets placed in an institution or a whole bunch of services are provided, it's very important to know what the basic problem is, and often that amounts to making some careful discriminations and informed decisions. Often the best people to do this are in fact trained professionals.

One important example is that very often the symptoms of depression in older people can mimic the symptoms of irreversible conditions such as Alzheimer's disease and, of course, depression is quite treatable and potentially reversible. To put a depressed individual into a long-term care facility because they look demented when they actually aren't, doesn't do either that person or the system any benefits.

Unfortunately, psychologists aren't covered under OHIP, which means that the possibility of agencies purchasing the services of psychologists is sharply reduced.

Another important service that psychologists provide is

training and direct service in managing the disruptive and disturbed behaviour that's often seen in older people with dementia: incontinence, wandering, the physical and verbal aggression, inappropriate sexual activities. All can be managed with relatively non-invasive behavioural techniques developed and provided by psychologists. Again, it doesn't seem that there are going to be very many possibilities for such services to be provided under this legislation.

One element in this legislation that looks very promising is the provision for evaluation of various programs and service delivery systems. We think this is a very important element in this act. In fact, it would be nicer if the act read that the minister "shall" provide grants and contributions, rather than "may" provide.

There's a great deal of what could be called social experimentation in this legislation. There are many ambitious plans that are intended to improve services, but that it actually happens isn't guaranteed. A properly planned and carried out evaluation, not just of components of the system but the entire legislation, could provide valuable information for program planners and for social planners in devising systems like this.

Related to that, we note that there is a tremendous amount of paper systems being set up by this legislation. There's a very formal appeals process. There is an extensive list of regulations being planned. There's a patient bill of rights, which is another innovation being made, that has its own set of documentation requirements.

All of this appears to be leading to a much greater degree of centralized control through the Ministry of Health over a system that in the past has been largely operated by local boards and agencies. Whether this is going to amount to a positive change is another thing that remains unclear about the whole legislative process.

Mr Jim Wilson: Thank you very much for your presentation. You've brought forward a perspective that we haven't seen before in terms of tying in your experience with Bill 101 to date and reminding us about, indeed, Bill 43 and the Regulated Health Professions Act.

I note in your written brief there's something that begins with talking about the stress that was placed on staffs during the implementation of the first piece of long-term care legislation, Bill 101. I can tell you, from our hearings around the province, you ain't seen nothing yet. Many of these staff, current employees of agencies like the VON and Red Cross, are simply going to lose their jobs and have to apply for jobs with the new MSAs, because the MSAs will be delivering 80% of service.

You mention psychologists being left out. I want you to just comment on that, because you're quite correct in that we don't have a clear idea as members of this committee, because the bill is mute on the point with respect to assessment and who will do the assessment and eligibility criteria. We did have a bit of a briefing that talked about current criteria and how that might change, but it's very unclear. In responding, I want you to expand on that to drive the point home about the need for proper assessment at the front end and how you think you might fit into the MSA structure.

1940

I'll give you a couple of options. One is that perhaps psychologists could be hired directly by the MSA, on staff of the MSA, and therefore not fall under the 80%-20% rule. However, you do make the point—and I'm unclear, and perhaps the parliamentary assistant will want to respond after you have a chance—as if they're purchasing services of a psychologist, I think you'd fall under the 20% rule and therefore MSAs may not be able to access your services even if they want to because there may be other priorities that they have to spend their 20% on. Do you just want to comment again on some of those areas?

Dr Helmes: Yes, reading the bill I came to much the same conclusions you did that there's a couple of ways things might be done, but the chances are there's not going to be very many possibilities for psychological services because it seemed most likely it would fall into that 20% section and I think there's going to be a lot of demand on that 20%.

Mr Jim Wilson: Do you think we should just scrap the 80-20 rule? Does it make any sense to you?

Dr Helmes: I'm not sure where that particular ratio came from—

Mrs O'Neill: Nor is anybody else.

Dr Helmes: —and I'm not sure why it's been set at that point and why it seems to be so fixed.

Mr Jim Wilson: No one knows. We're going to just introduce an amendment to scrap it. I mean, it is an arbitrary figure. It's ideologically driven by the current government of the day, as far as we can tell, because they aren't able to provide us with any paperwork. But I will ask the parliamentary assistant to clarify the purchasing of psychological services.

Mr Wessenger: Under Bill 173, agencies will be able to purchase psychological services, although it's not a mandatory service, it's permissive.

The other thing I might add is yes, it's within the 20% rule, though I would point out that most psychologists are professionals, and if the service is purchased from an individual professional, then of course it's exempt from the 20% rule.

There's one other point I just might make for clarification. I'll take this opportunity now rather than interject later. The bill does not in any way give greater authority or powers with respect to placement coordination services. That remains the same under the new bill. So the placement coordination under MSA has no more power than it has under the long-term care bill, 101.

Dr Helmes: My understanding is that under the current placement coordination system they can make recommendations as to the availability of beds, with the choice being left to the individual whether they want to take that. Is that going to continue to be the case?

Mr Wessenger: That is going to continue. It will still be a consumer choice, yes.

Mr Jackson: Well, let's not oversimplify it. There are three choices and you're off the list. That's it. Period.

Interjection: It's three strikes and you're out.

Mr Jackson: That is the bill. This gentleman presented, and I was here, not in this building, but I was in this city, when that was raised when 101 was being done.

Mr Wessinger: Just to clarify—

Mr Jackson: That's the legislation.

Mr Wessinger: No, that's not in the legislation. The legislation on Bill 101 basically provides—

Interjections.

The Chair: Order. The parliamentary assistant has the floor.

Mr Jackson: We still had it as a guaranteed service.

The Chair: Order.

Mr Wessinger: —that the placement coordinator—
Interjections.

The Chair: Order, please. The parliamentary assistant is explaining the situation as set out under the bill.

Mr Wessinger: Yes. The procedure is that the client will have the choice. Now, the reality is that people with emergency situations will have priority with respect to getting placements in the facility of their choice. Other people who are not in such high priority will have to go on whatever waiting list they prefer to go on, or they may select more than one waiting list, as many as they wish, to go on to the respective facility.

The other aspect is, a person who goes into a facility that's not their first choice will still have the option of staying on the waiting list of the facility of their choice. The individual, if they decide, because of time constraints or problems, that they have to or they want to go into a facility not of their first choice, can still stay on the waiting list for their facility of choice.

The Chair: We have to move on. Thank you both for coming before the committee and presenting.

ASSOCIATION OF ONTARIO
PHYSICIANS AND DENTISTS
IN PUBLIC SERVICE, LONDON REGION

The Chair: I call on the Association of Ontario Physicians and Dentists in Public Service, London region. Welcome to the committee.

Dr Rita Rabheru: Good evening. My name is Rita Rabheru. I'm a physician at London Psychiatric Hospital. On my right is Kiran Rabheru, a geriatric psychiatrist at LPH.

The Chair: You keep it all in the family.

Dr Rita Rabheru: Yes. Kiran also sits on the Thames Valley DHC's task force on geriatric psychiatry. We will both be available to answer any questions you might have after the presentation. I'm the vice-president of the Association of Ontario Physicians and Dentists in Public Service, and I'm here today representing the London-St Thomas branch.

I'd like to give you a little bit of background on the association. The Association of Ontario Physicians and Dentists in Public Service was formed in 1974. Our membership includes 400 full- and part-time salaried psychiatrists, physicians and dentists. They work in Ontario's 10 provincial psychiatric hospitals and also in the Comsoc regional centres for people who are develop-

mentally challenged. Our aim is to provide and improve the quality of medical care in Ontario's psychiatric facilities for patients, their families and the community. We do this by providing leadership, information and support to the front-line medical staff in the mental health care system.

This evening we are here to represent our patients, a group of people who are not able to represent themselves, those people with severe and chronic mental illness, some of the most vulnerable people in society today.

By some estimates, as many as 40% of the homeless we pass on the street every day have been our patients at one time or another. For the members of our association, they are people we share our daily lives with. To society, they're almost invisible. To us, they are ill with schizophrenia, manic depression, dementia and so on. Some of these illnesses are diagnosed as early as 18 or 19 years of age, and many of these people live to be 65, 70, even 80 or more. These are people with illnesses that so far are only controllable, not curable or preventable.

It seems to us that this makes them a long-term care issue, yet the severely mentally ill are not recognized in Bill 173. We would like to ask, where are the provisions for many young adults and adults in midlife who also require lifelong or periodic long-term care due to their mental illness? We believe that these patients should be considered under the bill in much the same way as adults with physical disabilities. We're here today to plead their case, to make sure that the cracks—and there are cracks—in the mental health care system don't get wider.

What's caused those cracks in the first place? Three things: (1) the move to deinstitutionalize that started in the 1960s; (2) the lack of specialized long-term treatment for the severely mentally ill in the community; and (3) simply a lack of funding. We don't see that those issues will be addressed in the long-term care reform or the parallel reforms being carried out in mental health care.

With that background, we'd like to provide the committee with our views on the lack of integration between mental health care and long-term care reforms. We'd also like to highlight the current and future funding problems for mental health care here in the London-St Thomas area and the consequences for patients and society.

Like many other groups who have appeared before this committee, we wonder where the funds are going to come from to support the creation of MSAs and fund the other initiatives in the long-term care reforms when funding for health care is already at a critical point.

1950

Looking specifically at mental health, there are already three funding cut initiatives under way. First, there's the expenditure control program. As you know, this will take money out of provincial programs and put it into the general treasury fund. At London and St Thomas, we were just recently informed that over \$12 million will be cut from our existing budgets over the next 18 months.

That's a considerable portion of our budget. It translates to about 150 of the 600 beds between the two hospitals. Does that mean this would result in the closing of one of these hospitals? What's going to happen to the

severely mentally ill who use those beds now? How is Bill 173 going to accommodate them?

Secondly, there are the cuts that will result from mental health care reform itself. It has been estimated that over 10 years the reform program is expected to reduce the number of psychiatric beds by a further 50%.

Thirdly, we must assume that the reforms now under way in the area of long-term care will have to be partially funded out of the present much-reduced mental health care budget.

The government has stated that no new money will be made available to support mental health reform. Changes will be made by reallocating resources, money and people within the existing mental health system. In other words, multiservice agencies and long-term care facilities will be receiving some of that reallocated money at the expense of the provincial psychiatric system. Yet many patients, elderly and otherwise, are in the provincial psychiatric system because they cannot be managed in long-term care facilities, such as nursing homes.

This means that money is being taken out of the pocket of the severely mentally ill, yet there is no clear understanding in Bill 173 as to how their long-term care is going to be managed or provided in the future. Who does have the responsibility for these vulnerable people? And what are the consequences for them and their families with all these current funding cutbacks and future reallocations?

Well, as most of you know, these people disappear to hostels, the street or nursing homes, where sometimes they have to be isolated or restrained because of their behaviour. Let me give you a couple of examples.

At London Psychiatric we have a 78-year-old man who has been our patient for several years. He has lived in one nursing home for about 15. However, whenever this man suffers stresses, such as the loss of a family member or the death of a friend, he acts out aggressively and the nursing home sends him to us. That's happened four times now. Because of the environment at London Psychiatric, such as a higher staff ratio and trained staff who can deal with his aggressive behaviour, he tends to calm down after a few days and we can send him back to his long-term care facility. We don't overmedicate him. We don't do anything other than treat his aggressive behaviour in an attentive and psychiatric manner.

What's happened to this man? Well, after he's had four of these episodes, his long-term care facility refuses to take him back because his behaviour disrupts other residents. So now we are responsible for finding a new place for him to live. That's likely to take at least two to three months.

How will he be cared for in the future when beds are closed? How will Bill 173 look after his very specific needs?

Another example is even more tragic. It concerns an elderly woman who was a patient at St Thomas Psychiatric Hospital for many years. Because of funding cutbacks, two years ago the hospital had to close a ward very quickly, within three to four months. There were several elderly patients in that ward. One of these women

was placed in a nursing home. After a short time in the home, she wandered off one night in the dead of winter because the home didn't have a secured facility. She was found frozen the next day in a cornfield. She'd been an inpatient of ours for 20 years or more.

How does Bill 173 address her needs? And how does it specifically address the care of the elderly with mental health problems?

As you know, the elderly are becoming a larger and larger percentage of the population. What may not be so obvious is the dramatic increase in mental illness that accompanies that fact.

According to studies, 8% of all Canadians over the age of 65 suffer from progressive dementia, and that's just one of the mental illnesses associated with aging. Ministry of Health studies indicate that 50% of all hospitalized elderly have at least one psychiatric problem. In long-term care facilities, 70% of their elderly residents exhibit personality or behaviour problems and 80% have a diagnosed psychiatric disorder or dementia.

Our association members and the work they do for patients in Ontario psychiatric facilities are on the forefront of these new and at times alarming changes in mental health care for the elderly. Six of Ontario's 10 provincial hospitals currently have community geriatric psychiatric programs. Here in London, we have been working since April 1993 to implement an elderly outpatient program. We presented our program to the district health council in the fall of 1993. Here we have a program that addresses the long-term community care issues for the elderly raised in Bill 173, yet because of all the changes, funding cuts, mental health reform and long-term care reform etc, the system appears to have become non-responsive to the very people it's supposed to be making these changes for.

Ontario's psychiatric hospitals have made great progress over the last 10 years in adopting more outpatient and home care approaches. As I told you, we've been trying to do that here in London for the last 18 months. Our association would welcome the chance to become even more involved in the implementation of the long-term care and mental health reforms currently under way. But to do this in a meaningful manner, we believe that the role of psychiatry and the current psychiatric system should be recognized in this bill as a partner and stakeholder in the reform process.

In closing, we thank you for your attention to this presentation and would welcome any questions you might have.

Mr O'Connor: Thank you for your presentation. We have heard from other people with concerns quite similar to yours. In fact, I believe we've been approached a few times and I think are to be approached further yet.

I guess the question I'd like to raise with you is, in looking at the basket of services that are being stated as a suggestion for a minimum for an MSA to develop, what would you suggest should be included in there that isn't included in there as far as the consumers you're advocating for, and would you see yourself involved in an approach to the MSA, the long-term care committee, to

make sure that if there is a client group, the consumers in that given area, those services could then be provided?

Dr Kiran Rabheru: If I may, Larry, I had some experience with the long-term care consultation process. In Elgin county I was part of that committee, and this issue with the chronic and severely mentally ill was raised by a number of committee members at that time. It seems to me this whole segment of population has, for one reason or the other, just totally been omitted from this package. I think there are many ways the two can be bridged together, but it requires further discussion on both sides, and willingness. I think the key issue is willingness and funding, and I'm not sure that either of those two things are present at this time.

Mr O'Connor: In your approach to the district health council, did you find it receptive to the needs of the client group that you serve?

Dr Kiran Rabheru: As Rita mentioned, we have been meeting for the past I think it's almost six months on the psychogeriatric task force. There's a very good representation from various segments. I think we have had some very healthy and productive discussions, but that's where we are at right now. The discussions may carry on for another few months before the report will be submitted to the minister by our committee.

Our fear is that a lot of the cuts are being implemented now and it may be too late to do anything about that by the time the report is submitted to the minister and something is done about it. It may be too late to reverse the process. Our concern is time. I think, given enough time and willingness to work together, we can probably come up with a good solution.

The Chair: Thank you for coming before the committee and focusing on some issues that we don't always hear about. I think that's been very valuable.

2000

ONTARIO HOME HEALTH PROFESSIONALS

The Chair: I call on the representative from the Ontario Home Health Professionals. Welcome.

Mr Ken Cook: I'd like to thank the standing committee on social development for the opportunity to present my views concerning Bill 173. I am president and a shareholder of Ontario Home Health Professionals, or OHHP. I'm also a member of the Ontario Home Health Care Providers' Association, HomeSupport Canada and a founding member of the Canadian Home Care Association.

I am currently on the London-Middlesex county transition steering committee, the London long-term care task force of the long-term care committee of council and the London multiservice system working group. I have particularly enjoyed being able to be involved with some of the local planning of long-term care. The chair of the long-term care task force has assured the committee that we are involved to make a difference, to work towards developing change and monitoring the system.

I have been fully involved in OHHP since its inception in 1988. We provide homemaking services in London and Middlesex county. We currently employ approximately 160 full- and part-time staff. OHHP provides approxi-

mately 125,000 hours of homemaking per year.

In 1991-92 the government performed the comprehensive long-term care redirection consultation. Many of us participated in the process. In the meetings I participated in it was obvious that the seniors were having difficulty accessing services. They realized services were there for them but were having difficulty knowing just who to contact for the particular service they required. They also preferred to be able to have choice concerning their care. The need for single access to services was an obvious conclusion.

It is interesting to note that choice had been a big concern identified in the 1991-92 consultation process, but by September 1993, when the paper Guidelines for the Establishment of Multi-Service Agencies was published, the goals for the MSA did not even mention the need for consumer choice. Could it be that the government realized that in its mandate the MSA would not only be the administrator but also the provider of the services and that they had done away with choice? Choice encourages competition and competition is needed to guarantee quality of service.

In 1994 the Resources of Wellness demonstration project began at 1194 Commissioners Road West, a London and Middlesex Housing Authority seniors' building. The goal of the project is to demonstrate and measure the effectiveness of coordinating services within a seniors' housing unit through the part-time employment of a resource awareness coordinator. A call for proposals was issued to the not-for-profit agencies only and Red Cross was chosen to provide the service. A tenant who receives home care services at 1194 Commissioners wrote the Honourable Bob Rae and the Honourable Ruth Grier. A portion of the letter states:

"At the February 14th meeting we were definitely encouraged to become part of the pilot, in order to give it a 'fair' test, but no one spoke the word 'mandatory.' We left the meeting under the understanding that we did have a choice, and that if we were we so chose to keep our existing worker, we were at liberty to do so, and that this right was guaranteed under the NDP policy. In my case, there was no decision to be made. I am extremely pleased with my homemaker and the two fill-in people I have had over the last three years. That should say something itself in the area of continuity."

A while later, this resident was reassessed and told in a nice way that she was really expected to comply. The letter goes on, "I cannot risk losing my service, and I don't wish to be labelled a radical, yet I feel I do have the right to speak up, and I do have the right to be allowed to make my own decisions."

In the consultation draft Long-Term Care Division Supportive Housing Policy, March 1994, one of the desirable characteristics of supportive housing is delinked services.

It states, "Future supportive housing initiatives should, as much as possible, feature projects where the service provider is not also the provider of the accommodation." Then it goes on, "This characteristic is at the core of consumer empowerment and is important in striking a power balance between the consumer and service pro-

vider." Why doesn't the government apply this same logic to Bill 173. Bill 173 has the service provider, one and the same as the service funder.

In Bill 173, one of the purposes of the act is, "To recognize the importance of a person's needs and preferences in all aspects of the management and delivery of community services." Also the bill of rights in Bill 173 states, "A person receiving community services has a right to be treated in a manner that recognizes his or her individuality and that respects cultural, ethnic, spiritual, linguistic and regional differences."

How will the government allow preference to be given in the delivery of service? What if some individuals don't like the way they're being treated? Today, in the provision of community service, there is a choice and there are alternative providers. But once the MSA begins providing at least 80% of the services, an individual will be left with a "Take it or leave it" situation. Unhappy clients will have to complain to the same agency that decides services. Vulnerable people will be afraid to speak out, feeling they may risk losing their services.

In Bill 173, I do not see any recourse if a person just does not like the service which is being directly provided by an MSA. The direct provision of services by the service provider takes away any competition, and competition has been proven to increase quality.

The Thames Valley District Health Council's long-term care committee's multiservice agencies discussion paper, January 1994, states: "We are concerned that the multiservice agency model as suggested may function like a monopoly and may lead to inefficiencies." "The provision of direct service by the MSA could result in a loss of quality in the services delivered and a loss of incentive to maintain or improve the quality of services." It continues, "It would appear that in the integrated model there will be virtually no competition which will challenge not-for-profit agencies to strive for quality services provision and cost-effectiveness in the use of public resources."

The Middlesex-London Home Care case managers, in response to the long-term care proposal, stated: "We believe the service brokerage system needs to be preserved in order to enhance accountability. We have found that a mix of profit and not-for-profit agencies fosters competition and thereby improves agency flexibility and maintains cost-effectiveness. We also think that there should be managed competition between non-profit agencies and for-profit agencies within the home care setting."

2010

The Council for London Seniors wrote in response to the community-based services provided by the multiservice agencies:

"Seniors believe in profit and non-profit agencies for service. Seniors also believe that an agency providing care needs to fit into accountability framework. Seniors do not believe in the total elimination of the private sector services. Services must strive to be flexible and meet the needs of seniors and their families. A day is 24 hours long and needs to be covered by community support services. Patient and family rights and choices

need to be taken into consideration."

A major advantage in the use of commercial agencies has proven to be their flexibility. Commercial agencies have developed expertise in scheduling visits or shifts during days, evenings, weekends and statutory holidays. We are flexible in response to the needs of our clients, office staff and home care. We provide capable, trained personnel. We stress continuity of the delivery of health care and have responded consistently with low minimum hours of care required to be cost-effective on individual assignments.

In the past, the minimum hours of care needed at one time to provide homemaking services in the home care program was set at a level of four hours. The minimum hours of care for both not-for-profit and commercial agencies has been reduced to two hours through efficiencies arising from competition. We are now able to provide one-hour service in special circumstances.

The benefits to the consumer and home care that stem from involvement of the commercial agencies has been reflected in the increased market share that the commercial agencies have gained over the past years. In 1992-93, commercial agencies were providing 67.1% of the services required by the Middlesex-London Home Care program. Assuming there is a high correlation between growth and consumer satisfaction in the competitive market, the quality of care offered by commercial agencies is demonstrated by their growth.

It is worth noting the experience in Manitoba. The Manitoba Home Care program, which in effect is an integrated monopoly, conducted an internal audit in 1992 which identified problem areas that need to be addressed. They were efficiency, timeliness and appropriateness of service. Their previous policy of exclusive not-for-profit home care service delivery has been reversed and commercial agencies are being invited to participate.

Another concern is the providing of at least 80% of the community home care services by the MSA. Will the MSA be able to provide these services? In London, in 1966, services were provided in nursing by the VON and community homemaking by the Red Cross. In 1981 in London the chronic home care program started as a pilot project and close to \$3 million worth of services were purchased. There was growth in nursing, homemaking and rehabilitation. Because of a need by a client for a special procedure to be done in the home and the fact that the VON was unable to do it because of its then current policy, commercial agencies already providing private care were approached. At the same time, the Red Cross was unable to meet all homemaking needs, so two commercial agencies arranged the training of homemakers. The homemaking needs continued to grow. As a result, the commercial agencies became essential.

In 1994, today, \$20 million of services are purchased by the Middlesex-London Home Care program with continued growth expected. In 1993-94, the VON had been given approximately a 9% to an 11% increase in nursing, but they were unable to handle all the growth in the home care program. The commercial agencies were needed to pick up the slack. The involvement of the commercial agencies has ensured that services needed in

the community have been provided. Without the involvement of the community agencies, the Middlesex-London Home Care program would undoubtedly have been less successful.

If the MSA is not formed in London by the public health department, it will mean duplication of resources, personnel and services currently provided to the Middlesex-London Home Care program. A new administrative bureaucracy to provide for the financial, human resources, legal, information systems and property management service that are currently provided to home care will result in a less efficient and more costly program for the taxpayer to bear.

The service agreements of the Middlesex-London Home Care program for 1993-94 show that the not-for-profit providers receive \$78.05 per professional visit—for example, physiotherapy—while commercial agencies received only \$55.55. Not-for-profit providers received \$37.30 per nursing hour while commercial agencies received \$37.21. Commercial agencies already provide less costly service than non-profit providers. Commercial agencies also bear the cost of home support worker training while not-for-profit homemaking agencies have received government funding to provide such training.

Over the last years, organizations like the Red Cross visiting homemaker services and the VON have been given 11th-hour bailouts to cover their deficits.

The Ontario Home Care Programs Association states, in its 1992 response to the redirection document:

"The introduction of a for-profit service provider sector in the past decade has impacted positively on the quality and accessibility of client services, contract negotiations and cost containment. Not only is no rationale offered by the government's preference, but it may prove unrealistic given the demand for the service that will result from program expansion. We question the capacity of the not-for-profit sector to expand to the degree that would be required to satisfy council and projected case loads. The more fundamental principle should be that available services are quality-assured rather than not-for-profit."

As I mentioned earlier, in Middlesex-London the VON has been providing nursing services for years but could not handle all the growth in the in-home visits in 1993-94.

Shouldn't the government pay attention to the concerns being raised by the very organizations whose members are directly involved in providing these in-home services? Without knowing the cost, can a single agency be cost-effective? Can a single agency properly handle such a case load? Can a single agency maintain or improve quality of care? These questions have been asked again and again, but to date no studies have been done.

I am concerned for any displaced workers. In letters myself and others have written to the government, we have been assured that the MSA will employ all displaced workers and that there is no need for concern. The government has also said no guarantees can be offered to workers. They have also said that laid-off unionized hospital workers will be given first priority for alternative jobs in the health care system. Commercial agencies do

not have a unionized workforce.

The Thames Valley District Health Council requested clarification that a shift to a predominantly unionized workforce would not, in the end, cost Ontario taxpayers and would not result in more and better service delivery.

Bill 173 states one purpose of the act as being "to encourage local community involvement in planning, coordinating, integrating, managing and delivering community services." Although the goal of the act is more community involvement, the decision-making is still in the hands of the minister. The minister is too far removed from local community issues. The Minister of Health must leave the job of planning and a good deal of the decision-making to the regional and community level.

Since appointments to the local district health council are approved by the minister, then the minister should allow them to manage local community care as they see fit. Excessive interference by provincial officials results in reduced flexibility at the local level and delayed implementation. DHCs must be given real authority to plan locally. Also, the evolution of the MSA from a community planning process will differ from community to community as needs differ.

I'd like to make the following three recommendations: That Bill 173 be amended by deleting section 13 which restricts the MSA in purchasing community support services. The local community should decide which is the most efficient and cost-effective way of delivering service to ensure choice, quality, growth and cost-effectiveness. In areas where the brokerage system has worked well, the option of continuing to provide community services in this way should be maintained.

2020

Another recommendation is the development of an effective, integrated information system that would enhance the coordination of community services. This information system can be developed on a provincial or a local level. This would have the immediate benefit of improving coordination of in-home services and thus improving access. This information system could also be used to educate the consumer and the physician about the services.

Recommendation 3: Local authorities should be given the ability to implement local decisions regarding the formation of MSAs in their community, as the needs vary from community to community.

All of us at OHHP have worked hard to build a business that is financially stable with a sound, respectable reputation within our community. Since I have been involved in OHHP from its conception until today, I am very much committed to the work that we do and am convinced that we do it very well. I also feel a responsibility to all the employees of OHHP who may be very much affected by the proposed integrated monopoly approach to the forming of MSAs.

I believe the government, the public sector, not-for-profit and commercial agencies can work together to strive to continually improve home health care in Ontario. It is hard to fathom that such a decision to limit the provision of in-home services by commercial agencies

could be based on ideology alone. A decision which could have such a terminal result to the commercial home care service providers should not be made without a thorough study. A study is needed to consider the effects not only to the commercial agencies but also to the consumer, government and the taxpayer.

Mr Eddy: Thank you, Mr Cook, for setting out so vividly your concerns regarding the act and the provision of home care. I appreciated your describing in the way you have how you've met locally the tremendous growth experienced in the need for home care. That's particularly interesting. I note your many concerns and I thank you for your recommendations at the end, which we should certainly take to heart and try to convince those who are not convinced of the need for.

I'm particularly interested in the point on page 7 under E, the duplication, and also your call that it's absolutely essential from your point of view that the department of health establish the MSA and run it. I wonder if you would elaborate then on that a bit for us, because I think it's important, and realizing that MSAs may be different from one community to another, but stressing the local input.

Mr Cook: Yes. I feel the Middlesex-London Home Care program has done an extremely good and efficient job in the past years, and yes, there is a problem perhaps with access to the system, which I feel an information system could take care of. But as far as the work performed by the Middlesex-London Home Care program, I think it is excellent. Everything's set up, there are trained professionals who do their work and do it well, so why try to duplicate what we already have? Just try to work with what we have and create an information system that would give access.

Mr Eddy: That was stressed by the Lambton county representatives who were here, too. They mentioned about having an information system, a 911 system, for instance, for the elderly, for people who need home care.

Mr Cook: Yes. There has been money spent in the last years by the provincial government on kind of a communication system, but it hasn't been that successful. But time changes and technology is always advancing, so I think it does really need to be looked at again.

Mr Eddy: First good step. Thank you.

NURSE PRACTITIONERS
ASSOCIATION OF ONTARIO

The Chair: I call the representatives from the Nurse Practitioners Association of Ontario. Welcome.

Ms Margaret Snyder: My name is Margaret Snyder and I'm the president-elect of the Nurse Practitioners Association of Ontario, and with me is Carolyn Davies. She is a nurse practitioner and she is a resident of the London area.

As you are well aware, the nurse practitioners have been entrenched in the system of health care for some time, although they've largely been let slip by the way. This past January the Ministry of Health announced that the nurse practitioner would be reinstituted into the health care system, and so we are here tonight to speak to the utilization of the nurse practitioner in long-term care

programming. The Nurse Practitioners Association of Ontario is pleased to have the opportunity to respond to the standing committee on social development regarding Bill 173, An Act respecting Long-Term Care. Nurse practitioners practising in primary health care are committed to health promotion and illness prevention and are highly responsive to individuals and family needs in the community.

The Minister of Health, Ruth Grier, announced in February the enhanced utilization of the nurse practitioner in the province of Ontario. The nurse practitioner position paper of February 1994 recognizes that since its inception, nursing has emphasized the integration of physical, mental, social, spiritual and environmental factors to maximize individual, family and community health and wellbeing.

In February 1994, the Ministry of Health published two documents: one, Nurse Practitioners in Ontario, a position paper, and secondly, Nurse Practitioners in Ontario: A New Beginning. The following definition of a nurse practitioner is taken from these documents:

"The NP is a registered nurse with additional nursing education that prepares her/him to provide the public with services, within the role of nursing, in all five basic components of comprehensive health services (promotion, prevention, cure, rehabilitation and support) and at all levels of the health care system...."

"The NP is a practitioner of advanced nursing. The services that she/he provides in the area of cure (diagnosis/assessment and treatment) are those that rest in the overlap between medicine and nursing and that can be safely and effectively given by either the physician or the nurse. Therefore, the NP should be, and should be seen to be, a practitioner of advanced nursing and not a second-level doctor or a physician's assistant."

The first point that we would like to address is regarding access of care. Consumers accessing long-term care have equitable access to services that are well-coordinated, meet their individual needs and are provided by the most appropriate care giver. The nurse practitioner should be a key player in assuring smooth access to long-term care services. Referral of the consumer to appropriate services is facilitated by full knowledge of the consumer's circumstances. This knowledge is based on thorough, comprehensive health assessment that recognizes physical, psychosocial, spiritual and environmental needs of the client.

Nurse practitioners are educationally prepared to provide comprehensive physical assessment, as well as assessment of pathophysiology, psychosocial factors and environmental factors with attention to family abilities to adapt and to cope with their changing circumstances.

2030

The nurse practitioner emphasizes health and wellness and supports the abilities of the consumer to live in the community. As well, the nurse practitioner also has the ability to recognize the risks inherent in aging and illness. Nurse practitioners have a history of functioning as team players, working collaboratively with consumers, health care professionals, and organizations.

Therefore, our recommendation is this: The Nurse Practitioners Association of Ontario recommends that nurse practitioners, who are educationally prepared for advanced nursing practice, to carry out comprehensive health assessments and to incorporate a holistic view of the consumer needs, provide a leadership role as assessors, care providers, coordinators, educators, and resource planners in long-term care.

Ms Carolyn Davies: I'll continue on with objective 2: preparation of registered nurses for advanced nursing practice. Registered nurses are essential and a key provider of long-term care and are critical for the successful implementation of the program. The expertise of the nurse practitioner promotes early identification of client problems, complications, or treatment of side-effects.

This is more likely to result in a quicker response time for the client to receive treatment alterations and a better-informed and more satisfied, healthier client. An example of that is that we can have a homemaker in or an NPA in, but if they're only looking at one small aspect of that client, they may miss certain kinds of symptoms that may be critical, such as a side-effect of a medication that they might not be trained to pick up. They may not notice that there's a deterioration of the client and so forth. So we feel that the nurse practitioner would be essential to be in there to be able to identify changes that might not otherwise be noted, especially when our clients are going to be at a higher risk in the community than they have been historically in the past.

At this time, registered nurses provide the backbone of long-term care. It makes good sense to provide the opportunity for some of these nurses to become educated as nurse practitioners. The appropriate use of this advanced-level nursing role has proven to be cost-effective in numerous past studies of nurse practitioners in primary health care.

Our second recommendation to the committee is that the Nurse Practitioners Association of Ontario recommends that registered nurses who are currently providing services that support long-term care programs be given the opportunity to be educated as nurse practitioners. Furthermore, we recommend that registered nurses be financially and administratively supported in accessing these programs and that funding mechanisms be shared among the benefiting agency, the provincial government, and the registered nurse.

Ms Snyder: Our third objective speaks to continuing education funding. To ensure quality assurance and consumer confidence in the long-term care model, it is essential that health care providers receive equitable and relevant continuing education. Historically, nurses have been an invisible provider of care, and ongoing professional development has been dependent on the organization's left-over funds.

The following example of a report on palliative care initiatives in Waterloo region of January 1994 indicates the inequality of funding that frequently occurs, and I'm quoting from that report: "The initiative will provide \$6,380 in funding for each of 111 physicians from across the province." This same report offers \$1,800 to the

entire Victorian Order of Nurses organization in Waterloo region for continuing education.

The skills and expertise of nurse practitioners can provide cost-effective services to consumers in long-term care. However, it is imperative that the funding mechanisms recognize the ongoing needs for professional development of all nurses to meet consumer needs in a highly technological and ever-changing environment.

The Nurse Practitioners Association of Ontario supports the commitment to fair compensation and job security for workers providing personal care and for ongoing in-service education towards their understanding of long-term care goals. The radical changes in the provision of long-term care makes it essential for ongoing education of consumers and their families about long-term care initiatives.

Our third recommendation is then: That the Nurse Practitioners Association recommends that the Ministry of Health and district health councils recognize the need for comprehensive continuing education programs for nurse practitioners and that resources for continuing education be a part of the funding packages on a level that is equitable to other health care providers.

Ms Davies: Objective 4: The collaboration of community health centres and multiservice agencies: The Nurse Practitioners Association of Ontario encourages long-term care planning to consider collaborative relationships between community health centres and multiservice agencies. This collaborative relationship will reduce duplication of services and resources and enhance seamless care for consumers.

Community health centres have a mandate to meet the needs of the unique community that they function in. Woolrich Community Health Centre, where Margaret works, for instance, has developed care giver support programs, hospice programs and other senior support programs. The nurse practitioner does home visits for frail elderly, and registered nurses provide a well-adult foot care and health assessment program.

There is a need to find ways to integrate existing programs of the community health centre with programs of multiservice agencies. Another example that I would suggest is that community health centres have already established a multidisciplinary approach to a view of the community. Their concept is based on community input, and the kinds of programs they provide are based on what the community has asked for. Plus you have almost all of the service providers, depending on the need of the community, and therefore long-term care providers can communicate beautifully between the two groups for support and backup. It would be a step between that and hospitalization.

So our fourth and final recommendation is: The Nurse Practitioners Association recommends that district health councils, multiservice agencies and community health centres work collaboratively to meet the long-term goals of providing comprehensive health care and resources for the local community.

On that note, I'd like to thank you for your attention to our presentation, and now we invite questions.

Mr Jackson: I want to thank you for your brief. It mirrors very closely many of the insights and suggestions from a presentation from your organization at about 12:30 today, in Toronto. So I really don't have any questions other than the fact that the issue of training has been raised by various groups who have raised the question as to who's going to do it.

You've indicated your willingness, with your professional expertise, in order to provide it, but I'm still at a loss as to determine how the legislation will encourage it being done or who will pay for it. I suspect that you'd be eminently qualified to do the training; it's just where that would occur. The previous deputant made reference to the fact that the government funds it when the non-profit sector does training but the private sector has been doing it on their own. Could you expand on that portion a little bit better for my understanding?

Ms Snyder: I think there are two issues of training that we're talking about. The one issue is the education of nurse practitioners, and that is now being addressed at the provincial level in terms of the educational programs that are being put into place.

We are recommending that the organizations that employ nurses in long-term care would very much benefit by integrating the nurse practitioner role into their agencies. Because it would benefit the organization and it would benefit the system, it would be very useful if the agency could, in some way, participate in the funding. We also talked about administratively: making it easy for nurses to go, giving them the time to go, giving them the support to go, and maybe some funding as well.

2040

Ms Elinor Caplan (Oriole): Since Mr Jackson doesn't have a second question and there are a few minutes remaining, could I ask a question?

The Chair: If members would like, we do have a bit of time. I think if I allow you a question, I will also allow a question from the New Democrats, if everyone is agreeable to that. Okay? Agreed.

Ms Caplan: Actually, I believe the group at 12:30 was the practical nurses, not the nurse practitioners.

Ms Davies: A little bit different.

Ms Caplan: They are different.

The Chair: Nurse practitioners are also very practical.

Ms Caplan: As I read the legislation, there would be nothing that would preclude nurse practitioners from participating as employees of an MSA or being part of an organization where the service was purchased from, but I'm intrigued and my question really is about how you would see the relationship between the MSA and the community health centre. You talked about a collaboration. Would you see it as a purchase of service on behalf of the clients who would be referred there, or how would you see that working? I see this as one of the flaws of the legislation that requires the MSA to be an employer as opposed to being able to get into service contracts and refer people and turn to those collaborative kinds of arrangements that you referred to. So I'm interested in how you would see that working.

Ms Davies: Just on your first point, we see nurse

practitioners very clearly. They're a very different group than the 12:30 group. They're an advanced level of nursing which functions very similarly to the role of a physician. About 85% of what comes into a family physician's office can be seen by a nurse practitioner. I often describe it as being like nurses in the north, where there are no physicians, but we've urbanized ourselves.

My vision, having a background in community health centres all of my career, is I see it at arm's length from the community health centre but working very closely with the community health centre, where there can be a collaboration of the kind of care that's required, such as that the long-term care staff could utilize the community health centre as a resource to problems that they might be having to address such as changing health status of a client who is starting to require either social work input, physician input, healer input, depending on the community that you're living in and what the staff is at the community health centre, which should be reflecting those clients who are being seen by the long-term care providers.

I see the multiservice agency as just making sure that, as we called it, the seamless care—that there aren't going to be the gaps we are seeing now where suddenly, because a person's health isn't improving, they're cut off, or because they can only get 40 hours a week, and because they need 50, they have to go into a nursing home. This is not appropriate.

We are going to be seeing people who are going to be at higher risk, more frail, requiring more assessment judgement so that we can keep them there longer, so that we can assess whether or not we can provide them more appropriate care within the community with the care givers who they care about and avoid hospitalization or nursing home care unless in fact it is the best care that is required, not because the care giver has been worn out or because relatives can't get respite care, but that we are providing those kinds of things, so that the community health centre can be there as a backup to opinions. They would have the 20-year history of what that person's been doing, they know their wellness record from when they were young 'uns, and now they're frail elderly.

Ms Caplan: There's nothing to prevent that happening now, is there, as you see the legislation?

Ms Davies: No, but at this point there are not a lot of community health centres and I think they should be a critical part of every single community. I see it as being part of the public health district that there be a community health centre in every single public health district so that people have an option between fee-for-service and a global community health centre.

Ms Haslam: That's actually what I wanted to follow up on. I'm interested in what you were talking about because I'm interested in accountability for consumers and I'm interested in input from the consumers and the lines of communication and helping to design a program and having access to their records. I wondered, when you talked about the community health centre doing that kind of thing, whether you feel that an MSA can be beneficial in those areas, similar to what a community health centre does.

Ms Snyder: I wish I had wonderful, brilliant answers for you. I don't. But I can tell you a little about how we function at our community health centre, and I don't think it's a lot different from other community health centres. We spend a great deal of time with community members and focus groups assessing what the community needs are and how they would direct their care. I'm assuming that long-term care or multiservice agencies would be doing the same kind of thing in the same community, so the initiative would be to bring those two together so we're not duplicating services or we're not having community health centres pull together focus groups and do program planning and multiservice agencies doing the same thing. How do we link them together to provide care?

The Chair: Thank you very much. I suspect we could go on for some time, and we really appreciate that you came before the committee. I also suspect that nurse practitioners will become a larger part of our lives and our system over the course of the next number of years. So again, thank you both for being here this evening.

PARA-MED HEALTH SERVICES

The Chair: If I could then call the representative from Para-Med Health Services, Ms Barbara Heasman. Welcome to the committee.

Ms Barbara Heasman: Good evening, ladies and gentlemen. My name is Barbara Heasman and I'm from Sarnia, a community where I grew up, went to school, took my nursing and have established my roots. I feel Sarnia gave me a great deal and now it's my turn to give some things back. I'm involved in many committees in the community, from the Y to education committees to church and a lot of health care committees.

For the last 10 years I wore two hats. I was a primary care giver as well as a provider of service. I am branch manager of Para-Med Health Services, a company that I am very proud to be part of that has 106 employees in our region with a full range of services. I was also a primary care giver to my handicapped mother. She was an arthritic confined to a wheelchair for 40 years, but this did not keep her confined from doing activities in the community. I guess that's where I learned it from.

I grew up in a very care-giving family. When my father died, I realized the job I had ahead of me. My mother could no longer remain in her own home, and her great desire was not to go into an institution. So we went to the point of putting on a granny flat. We brought mother to live with us, in our family, and she needed assistance. She spent an exorbitant amount of money over four and a half years to stay off the system and ended up in hospital in chronic care and died on welfare. I tried several times to access the government system, the system I was supposed to know, and I had a great deal of difficulty.

There is no question that the government long-term care programs need to be reformed. The past experience with the system and the growth of the population in need of long-term care are strong reasons for reviewing and making changes to the system.

Bill 173 as it is now presented, however, is not the

answer. The cataloguing of the needs may have been refined by extensive public consultation, but the solutions proposed to the identified problems are not always consistent or appropriate.

2050

There are two major issues that this brief addresses. They are the organization and structure of a multiservice agency and the government's distinction between for-profit and not-for-profit service providers. These issues are discussed in the following sections.

The government has proposed in Bill 173, part VI, the designation of agencies to provide long-term care services that are permitted under the Health Insurance Act. In doing this, it has proposed the largest organizational restructuring that this province has ever known, only surpassed in the country by an abortive attempt to unify the armed services by the federal government in the mid-1970s. The estimated number of jobs involved in the reorganization amounts to about 25,000, with the added disruption of 75,000 volunteers who freely give of their time to help their less fortunate neighbours. This is surely organizational overkill.

The reason for making this massive reorganization has been stated to be the difficulties experienced by those in need finding their way through the confusing and fragmented system that exists today. Trying to find information about what services are available, what are the eligibility criteria, and trying to access the services of the government system are justifiable reasons for reforming the system. But they do not justify the massive disruptive changes proposed. Simpler and less drastic corrective measures would be more appropriate.

Government intervention can take the form of three approaches: funding, regulation and reorganization.

Funding has certainly been tried to the limit, where it is beyond the capacity of the government to do more. Furthermore, more funding to the existing system has not produced the required incremental improvements.

Increased regulation is not popular today. The mood is that there is too much government intervention of this kind.

In the past, reorganization has been mainly confined to within the bureaucracy, and its impact is seldom seen outside the government work environment. The fact is that government departments exist in an almost constant state of flux, and to private companies this would be intolerable. Research data performed at the federal level show that one of the greatest causes of inefficiency and low morale in the public service is the consequence of organizational change. The public service takes it for granted, and it is not surprising that the same drastic measures are now being proposed or imposed on the health care system. In government, the constant reorganization is the major cause of low morale and dissatisfaction. We do not want this for our health care system. The problems identified can and must be rectified by much simpler and less drastic changes.

The MSA is not the best possible solution to the problems identified. The establishment of the MSA will disrupt the jobs and lives of about 25,000 persons across

the province. About 75,000 persons who give freely of their time to charitable volunteer work will be expected to transfer their allegiance, commitment or dedication from the worthy causes that they support to an unknown quasi-governmental organization. They will be asked to give up the traditions and culture prestige that they have acquired and contributed to in the course of their volunteer work. The proposal to designate MSAs has been made without responsible consideration of these persons. It could be said that the MSA proposal has been made with almost callous disregard for the jobs of workers and the respect of volunteers.

It seems that little thought has been given to the difficulty of creating the MSA. In our own community, for example, the organization required to perform the functions defined in Bill 173 would require about 400 part-time and full-time employees and absorb the contribution of some 800 volunteers. It is questionable whether the consumer will be able to deal with a larger organization than was possible with the greater diversity of smaller units.

The administrative challenge of the MSA does not seem to be fully appreciated. The cost, for example, of changing to this monolithic structure compared to the present diversity of smaller units will be very great. We no longer believe there is economy of scale in larger units. Communication problems will mount and service quality will deteriorate for sure.

Can the MSA provide for the special needs that motivate the volunteer? There is a great deal of pride and prestige involved with the memberships of organizations which have earned their credibility by a history of service to the public. While initially the volunteers may be willing to continue their service to the public, time will tell. But it is a dangerous presumption and a risk to be taking by the government without more careful study and consultation.

In conclusion, there are adequate reasons for the government to scale down the magnitude of the changes it is proposing in the establishment of an MSA, and it would be more appropriate to be considering smaller changes. There is ample evidence that the creation of a coordinating agency would be a far more appropriate step to take at this time.

In the discussion leading up to Bill 173, the government has persistently made it clear that it draws a distinction between for-profit and not-for-profit sectors. This distinction is carried into Bill 173 through subsection 2(1), where an agency is defined as a corporation without share capital. This eliminates the commercial sector from actively participating in the long-term care system. It seems that the government has introduced an ideological distinction into the debate by the exclusion, and it's unfortunate. The private sector has made substantial contribution in the past into these services and should not be eliminated at this stage. In fact, the distinction that the government has made is very artificial, and its rationale for doing so is weak. It is important that this issue be openly discussed and not quietly and discreetly avoided.

The first question that inevitably arises is, what is

wrong with profit and why this distinction? It's not a dirty word, nor is it an unacceptable pursuit. It seems the government is raising an issue that would have been more appropriate against Victorian capitalism than against present-day private investment. We believe this distinction should be eliminated from Bill 173.

Has anyone asked how much profit is being made from the health care sector of our economy? The minister has repeatedly offered the excuse that health care dollars should not go into profits, but what other motive is there for improving the efficiency and effectiveness of our delivery system? I can assure the committee that the profits being made in the company I work for are not such that anyone need apologize for or try to conceal them. Our financial statement is made available publicly on an annual basis and it shows that our investors are not taking advantage of government business.

The government of Ontario has many dealings with for-profit companies, not least of which are the international banks that fund the provincial deficit. The interest paid to them is much higher than the profits returned to the investors in the company I work for. Isn't it better to encourage Canadian investors to fund health care agencies than to be borrowing funds from international banks at a much higher interest rate?

The concern for profit is the best discipline for ensuring that expenditures are kept within the limits of revenue. This management style ensures that we do not have cost overruns and we do not have to return from time to time to the government for bailouts. Our performance shows clearly that there are still areas where improved efficiency could be attained, to the benefit of the taxpayer.

Mr Micawber in Dickens's *David Copperfield* sums it up well, as follows: "Annual income twenty pounds, annual expenditure nineteen nineteen six, result happiness. Annual income twenty pounds, annual expenditure twenty pounds ought and six, result misery."

There is no evidence to show there is any difference between the quality of service from for-profit and not-for-profit sectors. Within the community, each type of agency has its supporters who show preference for one or for the other. There is ample evidence that in some circumstances the private sector is more efficient than the publicly funded organizations. This varies from service to service, but it is very seldom that the commercial agency cannot match the cost of the not-for-profit agencies.

There is no evidence that employee compensation or job security is any different in the two sectors.

It is interesting to note that union employee pension funds are invested in for-profit companies, and these include health care service providers.

We believe the MSA constitutes an organizational overkill to correct problems which could be rectified by much simpler, less costly means. A coordinating agency would simplify the present system and satisfy the problems that have been identified. We ask the committee to reject part VI of the bill.

We believe the distinction between the for-profit and the not-for-profit sectors is restrictive, contrary to the best

interests of the clients, the employees and the public. We ask the committee to revise the definition of "agency."

2100

Mr Malkowski: Looking through your brief and listening very carefully to your presentation, I just want to ask one question. In terms of your service, do you have a formal mechanism for consumer involvement? Could you just make a few comments in terms of the minimum provision of services across the province and that concept, as well as the issue of standardization of services? I know the seniors' association has talked about the need for a formal mechanism to make sure that their needs are being served by any agency, so could you just tell us a little bit about your own agency in terms of that?

Ms Heasman: First and foremost, as I said, we have a complete range of services, from nursing through homemaking, the therapies, nutritional counselling if it's needed, social work. We supply eight-hour shifts as well as visits and we work a great deal in the community. It's very difficult. We work alongside the seniors' associations. We supply volunteers to run an annual boat cruise. Last year there was a VON community walk in our community and I had 69 workers from our agency get out and raise \$5,900 for the VON and we walked in their walk.

We work alongside our community agencies with the seniors whenever we are asked to go out. We run blood pressure clinics on a four-times-a-year basis. We do foot care clinics on a monthly basis. We work in close conjunction with the seniors.

We've got a lot of volunteers within our agency and family members from those employees, but it's very hard to bring volunteers in from the community because, you must remember, we're in the for-profit sector. They tend to volunteer more in the not-for-profit sector. But we do work very closely with them. I hope that's answered your question.

Mr Malkowski: Maybe I wasn't very clear. Let me just rephrase that. What I want to know is whether your organization actually has some type of formal mechanism within the organization for consumer participation, if, for example, they have concerns about improving the standards and so on.

Ms Heasman: We have a mechanism by which we get evaluations in from our clients on a regular basis, clients and families of clients. From those evaluations, if there is need for improvement or a change in the way we're providing services, we change what we're doing. We're there to service the consumer. As far as a formal mechanism in a large way, I would say no, we do not.

The Chair: I'm sorry, we're going to have to finish at this point with this submission, but may I thank you again for coming before the committee and coming over from Sarnia.

PARENTS OF TECHNOLOGICALLY DEPENDENT CHILDREN

The Chair: Our next presenter is from Parents of Technologically Dependent Children, Grace La Forest, president. We welcome you to the committee, Mrs La Forest.

Mrs Grace La Forest: Good evening, ladies and gentlemen. My name is Grace La Forest and I'm president of a group called Parents of Technologically Dependent Children. I would like to say that perhaps you have seen or heard a more polished presentation this evening. I'd like you to bear in mind that I am the parent of a technologically dependent, medically fragile child. I've had limited time to do this, but I hope I can manage to get my point across.

After reading Bill 173, one could be forgiven for assuming that children never were, are not currently and, probably most disturbing of all, will not be recipients of long-term care.

To deny such a truth is poor government on many levels. First, it is a blow to the very fabric of our society, one which is supposed to honour family values; second, it is fiscally irresponsible; and third, it subscribes to a system which violates human rights.

In respect to a blow to the fabric of our society, in the province of Ontario, children always have been the recipients of long-term care. Whether this be in an institutionalized, quasi-hospital setting such as Bloorview, a group home, a home share program or in their own home, they have been receiving long-term care. As a society, we have decided that institutionalized, segregated care does not value children in a constructive or supportive manner, and this PTDC heartily endorses. However, by failing to provide alternatives, we are denying the initial need for an alternative to parental support. History shows us that there always has been a need for this type of support. Under this bill, it is non-existent.

Equally as disturbing is the lack of in-home support so that the above need is at least delayed. The integrated homemaker program, for example, is only available to those over the age of 18. The conclusion we are left to draw, therefore, is that care giving to children who have high-care needs is to be left with the birth family. Families are being asked to take their children home from hospital and to accept the role of doctor, nurse, physiotherapist, occupational therapist, respiratory technologist, social worker and case manager, with no support for the next 18 years—that is, if an alternative is even available at that time.

In the last decade we have witnessed an increase in the degree of medical involvement with children being discharged from hospitals to home care. With the advancements in medical technologies, the need for this level of support can only be expected to increase. I am reluctant to call these advancements progress, since true progress can only be evaluated on the overall impact on society, and unless we are prepared to be responsible to those who are left most vulnerable, it is not progress.

More than enough studies have been done to prove to this government that families of medically fragile children living at home are experiencing major effects from the burden of home care. The negative impact on the family is also greater when they experience problems and hardships associated with getting home care services. Contrarily, it is widely accepted in the medical profession, as well as by parents, that children ought to live at home.

Therefore, we know we have an identified need and we know the goal to be a good and beneficial one, and yet according to this bill these children are non-existent. Our families are living the family values which we are so keen to say are important to society, and yet this bill does not support them.

In the area of fiscal irresponsibility, since the move to deinstitutionalization began, and in the absence of alternatives, children have been booked into respite programs and left there. Without dwelling on the psychosocial trauma that the family must have gone through to be driven to this act, the financial implications warrant attention. A reality check would inform the government that not all families are able, for any number of reasons, to look after a child who has high-care needs. Where is the provision for this eventuality?

In a family system, the health of one member often has an effect on the health and functioning of other members of the same family. For some, especially mothers, there are more physical illness problems. In addition, the psychosocial effects, experienced as disrupted social relationships, personal strain and economic strain, are greater in these families than in families caring for less medically involved chronically ill children. The cost of not providing the care, therefore, needs to be taken into consideration.

Shifting the cost from an acute care hospital, at an estimated per diem rate of over \$2,000, to individual families can only have long-term implications which we pay for now or we pay for later. Mothers of these children face a future of poor health, depleted savings, if any, and no pension—poor rewards for years of dedication.

2110

With respect to subscribing to a system that does not provide for basic human rights, in the present system of home care policy a family of a technologically dependent child may be eligible to receive up to 40 hours per week of nursing services in-home. This usually means five nights of nursing with the family covering the weekends. This is of course a strain, but with the father and mother working in shifts, it can be accomplished.

However, let us look at the single mother. The nurse leaves at 8 am on Saturday morning and the mother is on duty until Monday night at midnight. That is a working shift of 64 hours. This shift is extended to 88 hours in the case of a holiday weekend.

The Geneva Convention ruled in 1990 that sleep deprivation was a minor cruelty and subject to punishment by international law. They define sleep deprivation as being forced to go without sleep for a period of 24 hours.

It should be kept in mind that during these 88 hours, the mother may be called upon to attend to a ventilator, do tracheostomy care, gastrostomy, central venous line, run IVs, as well as prepare meals, launder, housekeeping, do shopping and do personal care for her child or children and herself.

As you can see, currently we are subscribing to a system which does not even provide basic human rights,

and if Bill 173 is to remain as is, with children not mentioned specifically, there are no guarantees that this condition will be improved.

We would like to recommend (1) that children who have high care needs are clearly defined as recipients of long-term care, (2) that services to children with high care needs be defined under the mandatory basket of services, (3) that services available to care givers of the elderly or disabled adults also be available to care givers of children with high care needs, and (4) that alternatives to institutions be made available for those children whose families are no longer able to support them.

Thank you very much for allowing me to make this presentation. I'll accept your questions.

The Chair: Thank you very much, and if I can just say, we are really very pleased that as a parent you have come forward to make your presentation.

Mrs O'Neill: Thank you very much for coming to this committee, Mrs La Forest. Could you just tell me a little more about what your thoughts are on recommendation (4), just to describe what you mean by that?

Mrs La Forest: That alternatives have to be made for families who cannot provide for their own children.

Mrs O'Neill: What alternatives are you thinking of here?

Mrs La Forest: Perhaps an expansion into a home share program; more areas in supported living might be looked at. There has to be something. At the moment, there is nothing.

Mrs O'Neill: All right. If I may, I'd like to ask Mr Quirt to tell us how he feels about your recommendations, if any of them fit in presently to Bill 173, particularly recommendations (2) and (3), with respite care I presume as part of recommendation (3).

I do think that you bring very real needs, and I do think that particularly in the preschool years these needs are very great, and the transition time of parents to get used to a whole new set of responsibilities. So perhaps the parliamentary assistant or the ministry officials could suggest how these, particularly (2) and (3), could, may or do fit into Bill 173.

Mr Wessinger: I'll ask Mr Quirt to indicate how these services might relate to the multiservice agency.

Mr Quirt: Recommendation (1) that you make, that children who have high care needs are clearly defined as recipients of long-term care: We have been clear about indicating that people who need health care services at home of all ages are clearly clients of the long-term care system, and as you would be very much aware, some of our clients who present the greatest challenges to our long-term care system are those children and families who do extraordinary things to allow children to maintain as normal as possible a lifestyle in the community.

We think that clearly the core services in the bill, the therapy services, the nursing services, are very much available for children, whether they're at home—and as you're probably aware, our current home care system is involved in delivering those types of services to children at school and that will definitely continue in the range of services that MSAs would provide.

We hope that by equipping MSAs with more flexible eligibility criteria and a system that allows the MSA to respond to a client's needs rather than responding to everybody on a 40-hour or a 60-hour-a-week basis, that if there's more targeting of resources to those clients who are most in need, there will be more flexible responses available to clients of all ages of the MSA.

I know that in London here over the next two years we'll be piloting a weekend relief program that we hope will address some of the concerns that you've raised about, particularly, single-parent care givers who, as you've rightly pointed out, have an incredible workload that they face when left to their own resources to care for their child at home. We hope that over those two years we'll be able to prove that providing weekend relief to families in that situation will be an extremely cost-effective and beneficial program. I'm hoping that the pilot will prove that eligibility criteria for MSA services across the province might be adjusted to allow for that in particular circumstances.

I am interested also in your suggestion about the sharing of responsibilities among families or the matching of families for sharing care giver responsibilities, and I understood that's what you meant by your suggestion that with the appropriate coordination and support, families might pool their resources to give respite to other families.

Mrs La Forest: No, actually that wasn't. The very thought of providing respite to another child who has high care needs just scares the blazes out of me, to be honest. What I was talking about was there is a program in London called Home Share, and certainly there has been a lot of criticism of that program because they get better support than the birth family. They get paid; they get respite every second weekend, for example. However, the need for that program is very, very strong, because what happens when there is no alternative? As far as I understand, the people who are being served right now are the only ones who are being funded. The people on the waiting list are not to be funded.

Mr Quirt: We'll certainly look into the situation with that particular program. Clearly, we've identified in the bill that respite for care givers is an important priority for the long-term care reform in general, and I might say that we're also committed in our policy documents to studying with other affected ministries in program areas the issue of direct compensation to family care givers. That's a very complicated area, as you would know, and it affects all aspects of human service delivery.

But the point that you're making is well made, that resources are available to support children in other than the family situation; it's time we looked at the options available to us to make it easier financially for families to continue their care giving role. Certainly we want to explore things like how the tax system might be used to make it easier for families in your situation to continue to provide the care that you are providing.

Mrs La Forest: Thank you. One of the things that I have discovered in many years of dealing with health services is that if children are not mentioned specifically, then they often don't get the service, and that is where

the concern comes, that they be mentioned specifically.

Mrs Caplan: Would the ministry have any objection to that kind of amendment that would give that comfort?

Mr Wessinger: Certainly we can ask legal counsel to take a look at it.

The Chair: One of the things that was of interest to me and I think perhaps to all members of the committee is that I was not aware of your organization, but we do have in our own areas people who may be in a similar situation who will ask about what kind of support or organizations there are in the province. I wonder if you have a pamphlet or a letter about your organization which you could perhaps make available to the clerk and we could circulate that. Because I think this is an area where we do run into these issues and, again, having you as a parent come before the committee has been extremely helpful in underlining what you see as the problems there. Could you do that?

Mrs La Forest: Thank you very much. I'd be more than happy to provide you with a brochure, certainly.

2120

FRIENDSHIP IN ACTION

The Chair: If I could then ask our last presenter for this evening to come forward, Friendship in Action. I believe it is Linda Snedden, the executive director.

Mrs Snedden, I know you've been here during a good deal of the presentations. I want to assure you that while we've all been here for a long time, we welcome you as well to the committee and we appreciate the fact that you've taken the time to come. We also have a copy of your submission, so please go ahead.

Mrs Linda Snedden: Thank you. Good evening, ladies and gentlemen. I know it is late and you will be glad to know that I have a very short presentation.

Since its inception in 1977, Friendship in Action has functioned as an advocacy-visiting program to support isolated seniors. A student home help service received Ministry of Community and Social Services funding in 1984 in response to the need for more practical home help tasks for seniors. It has since been, of course, taken over by the Ministry of Health long-term care division. Volunteers in both our programs perform a wide variety of services, as diverse, in fact, as the seniors they serve.

As a member of the Ontario Community Support Association and funded by your ministry, our agency has participated in questioning and lobbying in preparation for long-term care reform. Therefore, questions about the multiservice agency concept have been in large measure addressed by that organization. I do however, from personal experience in dealing with older people in need of service, have some very real concerns about the criteria for home care.

The original concept of home care was to prevent costly acute care hospitalization, and yet, should a patient be discharged over a holiday weekend and no home care referral made, it can be another five days at home alone without any support systems. This in fact was the case of Molly after major stomach surgery for cancer.

The need for nursing services is not necessary for an

independent woman with major disintegration of her spine. However, Annie, with a history of surgeries and a bad heart, has equipped her bathroom so she can bathe herself and is denied a homemaker to vacuum, prepare meals or clean the bathroom. Is your ministry advocating health promotion or crisis response? Does Annie have to have another heart attack to receive help pushing a vacuum and cleaning a tub? There is an option for Annie here: an expensive physiotherapist, in order to justify a homemaker. Is this reasonable and is it economical?

While the government is telling us to consolidate and amalgamate and reduce expenditures, we see existing home care programs hiring additional staff and expanding service. We see homemakers getting groceries where \$5 private delivery services exist. We see homemakers playing cards, walking clients and sitting out the mandatory two or three hours while the other Annies wait and an 83-year-old spouse with cataract surgery—and recent surgery—is required to provide homemaking and nursing to a Parkinson patient who cannot stand without falling.

Charlie, a blind diabetic with a homemaker three times a week, tells us that there's not enough for a homemaker to do in his bachelor apartment. Archie, with a son and daughter next door, both teachers, both home all summer, still has a homemaker every day for two hours while another senior is sent home after ankle surgery, no cast, pins in place and told to put no weight on her leg. No need for a nursing service here, so she had to struggle to make her own bed, get her own meals, do laundry and let her other housework go. The risk, obviously, is one of further acute care hospitalization. In other words, I think that there is a problem with assessments.

In developing a service plan, Bill 173 talks about prescribed rules and standards when assessing a person's eligibility. Are these rules and standards the same across the province? Who sets the rules and standards? Are they flexible and coordinated with non-profit support agencies? Are they meeting the consumers' needs? I hear from many seniors that they are not. We respectfully submit, on behalf of seniors in Ontario, that these standards or lack thereof are at the core of rising home care costs and in real need of reform.

Home care staffing levels have risen rapidly as they assume more volunteer roles, yet funding levels for volunteer services have been flat-lined for two years. Volunteerism is an essential component in the delivery of community-based services. In addition to the valuable work-in-service provision, a significant amount of money is made available for community support services.

The open-ended home support assistance is not defined in this bill. Will there be an overlap between the eligibility of community services and homemaking services? For example, if homemakers provide transportation, what happens to the volunteer-based transportation service? Members of the Ontario Community Support Association provide these home support services. We see the deficiencies and strengths of the MSA plan and strongly advocate that OCSA be involved in the development and definition of service provided.

We do applaud the leadership demonstrated by the provincial government through the development of Bill

173, which provides the basis for the foundation of the new long-term care system. Most particularly, we appreciate the opportunity to work in partnership with the government and to have input with our colleagues at the community level to bring about the redirection of long-term care.

Mr Jim Wilson: Thank you, Mrs Snedden, for your presentation. It's a little unclear to me, however, what services Friendship in Action is currently delivering and how you're doing that.

Mrs Snedden: We are delivering a visiting service, which is part of the long-term care services of home support, and the student service is a home help service as well as providing an intergenerational contact with students and seniors in the community.

Mr Jim Wilson: Are you doing that primarily through volunteers?

Mrs Snedden: We are.

Mr Jim Wilson: Do you have any concerns about what will happen to those volunteers, whether they'll show up to also work for the MSA once it's put in place?

Mrs Snedden: I think that is being overdramatized somewhat. I do believe there's lots of evidence to substantiate that volunteers will work for certain loyalties. You will volunteer for cancer if you've had cancer in your family, that sort of thing. Many of my volunteers volunteer to work for seniors because they're missing a grandparent or they've just had a grandparent die or a parent die, that kind of thing, and feel very strongly about that. I think they will continue to work for Meals on Wheels or friendly visiting or transportation services, whatever, as the MSAs develop. I don't see that as being a major problem.

Mr Jim Wilson: It's a major problem for groups like the Red Cross, which in one area of the province has 10,000 volunteers and does not believe that people will either want to fund-raise or volunteer for what essentially will be perceived as a government agency. It may not be a problem for smaller groups.

Mrs Snedden: It depends on how it's worked out, but I think the people will still volunteer for the Red Cross within an MSA, is my reading of the way it will work. I do see a loss of volunteers as homemakers take over some of the roles that volunteers have provided. If you feel that you're not significant and that your services are not needed because someone else is there playing cards, you're certainly not going to volunteer to provide the socialization and visiting and outings that you formerly did.

The Chair: Thank you very much for coming before the committee this evening.

Members of the committee, before adjourning, just a business note: The clerk is handing out the agenda for tomorrow. If I could remind everyone that we begin at 8:50, I expect us all to be here shiny, bright, alert and ready to go.

With that, then, the committee stands adjourned until 8:50 tomorrow morning.

The committee adjourned at 2133.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

***Chair / Président:** Beer, Charles (York-Mackenzie L)

***Acting Chair / Présidente suppléante:** McGuinty, Dalton (Ottawa South/-Sud L)

***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)

Carter, Jenny (Peterborough ND)

Cunningham, Dianne (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

*O'Connor, Larry (Durham-York ND)

*O'Neill, Yvonne (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

*Rizzo, Tony (Oakwood ND)

*Wilson, Jim (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Caplan, Elinor (Orléans L) for Mr McGuinty

Harrington, Margaret H. (Niagara Falls ND) for Mr Hope

Haslam, Karen (Perth ND) for Ms Carter

Jackson, Cameron (Burlington South/-Sud PC) for Mrs Cunningham

Johnson, Paul R. (Prince Edward-Lennox-South Hastings/ Prince Edward-Lennox-Hastings-Sud ND) for Mr Martin

Malkowski, Gary (York East/-Est ND) for Mr Hope

Sullivan, Barbara (Halton Centre L) for Mr Eddy

Wessinger, Paul (Simcoe Centre ND) for Mr Owens

Winninger, David (London South/-Sud ND) for Mr Martin

Also taking part / Autres participants et participantes:

Ministry of Health:

Quirt, Geoff, acting executive director, long-term care division

Wessinger, Paul, parliamentary assistant to the minister

Clerk / Greffier: Arnott, Doug

Staff / Personnel:

Boucher, Joanne, research officer, Legislative Research Service

Gardner, Dr Bob, assistant director, Legislative Research Service

CONTENTS

Wednesday 24 August 1994

Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée, projet de loi 173, <i>M^{me} Grier</i>	S-1917
Association of Local Official Health Agencies	S-1917
Richard Cantin, president	
Dr Helena Jaczek, past president	
Alzheimer Association of Ontario	S-1921
Angela Morris, chair, public policy committee and immediate past president	
Bernard Leech, member, public policy committee and president, Alzheimer Society of Peel	
Susan Kitchener, manager, public policy	
United Way of Greater Toronto	S-1926
Gordon Floyd, member, board of trustees	
Municipality of Metropolitan Toronto, homes for the aged division	S-1932
Dennis Fotinos, chair, Metro Toronto community services and housing committee and Metro Toronto councillor	
Sandra Pitters, assistant general manager, homes for the aged division	
Association of Municipalities of Ontario	S-1936
Reg Whynott, vice-president and chair, health and social development committee	
Janice Mills, member, health and social development committee	
Phil Johnston, member, health and social development committee	
Canadian Pensioners Concerned, Ontario Division	S-1941
Mae Harman, president	
Registered Practical Nurses Association of Ontario	S-1944
Verna Steffler, executive director	
Jan Hallett, president-elect	
Med-Care Health Services	S-1947
Mary Jo Dunlop, vice-president and chief operating officer	
County of Lambton	S-1949
Jim Foubister, chair, health and social services committee	
Elizabeth Tenhoeve, member, health and social services committee	
Golden Years Advisory Committee for Schizophrenia	S-1952
Martha Jean Noble, chair	
Waiting with Concern Committee	S-1955
Deborah Jazey, chair	
Brian Dunne, executive director, Participation House, London area	
London Regional Psychological Association	S-1959
Dr Edward Helmes, member, executive committee	
Association of Ontario Physicians and Dentists in Public Service, London region	S-1961
Dr Rita Rabheru, region representative and AOPDPS vice-president	
Dr Kiran Rabheru, member	
Ontario Home Health Professionals	S-1963
Ken Cook, president	
Nurse Practitioners Association of Ontario	S-1966
Margaret Snyder, President-elect	
Carolyn Davies, member	
Para-Med Health Services	S-1969
Barbara Heasman, branch manager, Sarnia	
Parents of Technologically Dependent Children	S-1971
Grace La Forest, president	
Friendship in Action	S-1973
Linda Snedden, executive director	



S-65

S-65

ISSN 1180-3274

Legislative Assembly of Ontario

Third Session, 35th Parliament

Assemblée législative de l'Ontario

Troisième session, 35^e législature

Official Report of Debates (Hansard)

Thursday 25 August 1994

Standing committee on
social development

Long-Term Care Act, 1994

Chair: Charles Beer
Clerk: Doug Arnott

Journal des débats (Hansard)

Jeudi 25 août 1994

Comité permanent des
affaires sociales

Loi de 1994 sur les soins
de longue durée

Président : Charles Beer
Greffier : Doug Arnott



50th anniversary

1944 – 1994

50^e anniversaire

Hansard is 50

Hansard reporting of complete sessions of the Legislative Assembly of Ontario began on 23 February 1944 with the 21st Parliament. A commemorative display may be viewed on the main floor of the Legislative Building.

Hansard on your computer

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. For a brochure describing the service, call 416-325-3942.

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

Subscriptions

Subscription information may be obtained from: Sessional Subscription Service, Publications Ontario, Management Board Secretariat, 50 Grosvenor Street, Toronto, Ontario, M7A 1N8. Phone 416-326-5310, 326-5311 or toll-free 1-800-668-9938.

Le Journal des débats a 50 ans

Le reportage des sessions intégrales de l'Assemblée législative de l'Ontario, fait par le Journal des débats, a commencé le 23 février 1944 avec la 21^e législature. Une exposition pour marquer cet événement est étalée au premier étage de l'Édifice du Parlement.

Le Journal des débats sur votre ordinateur

Le Journal des débats et d'autres documents de l'Assemblée législative pourront paraître sur l'écran de votre ordinateur personnel en quelques heures seulement après la séance. Pour obtenir une brochure décrivant le service, téléphoner au 416-325-3942.

Renseignements sur l'Index

Il existe un index cumulatif des numéros précédents. Les renseignements qu'il contient sont à votre disposition par téléphone auprès des employés de l'index du Journal des débats au 416-325-7410 ou 325-7411.

Abonnements

Pour les abonnements, veuillez prendre contact avec le Service d'abonnement parlementaire, Publications Ontario, Secrétariat du Conseil de gestion, 50 rue Grosvenor, Toronto (Ontario) M7A 1N8. Par téléphone : 416-326-5310, 326-5311 ou, sans frais : 1-800-668-9938.



LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL DEVELOPMENTCOMITÉ PERMANENT DES
AFFAIRES SOCIALES

Thursday 25 August 1994

Jeudi 25 août 1994

The committee met at 0856 in the London Convention Centre, London.

LONG-TERM CARE ACT, 1994

LOI DE 1994 SUR LES SOINS DE LONGUE DURÉE

Consideration of Bill 173, An Act respecting Long-Term Care / Projet de loi 173, Loi concernant les soins de longue durée.

The Chair (Mr Charles Beer): Good morning, ladies and gentlemen. I'd like to call the standing committee on social development to order. We begin our Thursday, August 25, session here at the London Convention Centre.

REG HEASMAN

The Chair: Mr Reg Heasman, is our first witness this morning. Welcome to the committee. We have a copy of your presentation, so please go ahead once you're settled.

Mr Reg Heasman: Thank you, sir, and thank you to the committee. I assume that you rearranged your schedule so that you could encompass far more people here in London. I thank you for that. I also want to add thanks to Mr Arnott, the clerk. I'm sure he doesn't get as much credit as he should get for the good work that he does.

The Chair: On behalf of the committee, I accept that for Mr Arnott. We know all the work that he and his staff do, so we're glad you noted that.

Mr Heasman: The agenda leaves me as just Reg Heasman. I'm afraid I am very much that. I do not come here representing anybody other than my own views. I do not have a constituency that I speak for.

As the front page of my brief will tell you, I am a retired federal public servant. Since I retired in 1988, I suppose I have devoted a very large amount of my time to volunteer work. In fact, I might almost refer to myself as being a professional volunteer. With that in mind I have chosen as the subject to talk about and to address you on that of volunteers and the multiservice agency.

The organizations which I am involved with: I'm a board member of the United Way of Sarnia-Lambton; I am a board member of the Strangway Centre for Older Adults, which is an adult centre in Sarnia; I'm a member of a group called the Senior's VIP Service, the volunteers in public service; I'm on the board of a group called the Lambton Seniors' Association; and I'm also a member of a group called the Lambton Alliance, which is a pretty hot ginger group, which has as its mandate to ensure that the point of view of consumers is well covered in your deliberations.

Last year, I took part, with a group, in organizing and

producing a series on volunteers on our local TV program. This series covered a complete spectrum of volunteer activities. The thing which was driven home to me very, very clearly indeed was the enormous diversity of activities that volunteers contribute to and the extent of the dedication of volunteers in what they do.

It became very clear indeed to me, and I am fully convinced of it, that the contributions that volunteers make forms the backbone of our social infrastructure. I think our society would collapse if we did not have the help of volunteers. What this represents is part of our culture, that we have a concern for our fellow human beings, and it's a key indicator of the wellbeing, of the health of our culture.

Volunteers also play a very, very large part in our health care. It's on the relevance of this that I am concerned today. I want to talk about volunteers in relation to this remarkable piece of legislation that we have before us.

The first point I want to make to you about this bill is that I sincerely believe it is wrongly named. It's called the Long-Term Care Act. It isn't in the least bit about long-term care. It's about long-term care services. I think, from what I saw of you on television, the number of people who came to talk to you were mainly people who had interest in the services which you people—you, the government—fund for long-term care.

I would suggest to you that it would be much more appropriate and it will drive home the point much more clearly if this act were renamed, and there is a clause in the act, somewhere near the end, and I would suggest that one of the things the committee should seriously think about is changing the name of the bill to that of long-term care services or even long-term care service funding, which is really what it's about.

In reality, long-term care is largely outside this government system. There is far more long-term care which is given within the community which has nothing at all to do with the services that you people fund. It's the care of the elderly spouses of one for another; it's the love that the parents of a handicapped child have in caring for him or her; it's the care which is provided by family, by neighbours and by friends. That represents the bulk of the long-term care. That's the care which is ongoing and going on all the time.

The next level is that of the contribution that volunteers make, their dedicated efforts through their organizations. The contribution that this long-term care service legislation which you have before you is mainly con-

cerned with that part of long-term care for which you provide the funding for purchasing the services.

An example of this came home very clearly to me at a time when I was involved with our local Alzheimer society. The district health council had a study done in which it tried to get a measure of the prevalence of Alzheimer disease in our community. The consultant report that came out came to the conclusion that there were probably around 500 cases of Alzheimer in the Lambton county region. Yet, by a completely independent approach to that determination, a determination which I think is fairly reliable, with some mathematical validity behind it, the thinking came out that there were probably between 1,500 and 1,700 cases of Alzheimer disease in Lambton county. Of course, the difference between those two numbers is really a measure of the amount of people with this debility, with this condition, who are being cared for outside of the system.

I'd like to move on now to more about the volunteer piece. Over time, within the systems that you people are concerned with, volunteers have built up a range of services that are integral to that system. Things like Meals on Wheels are very largely dependent upon the contribution that volunteers make. Sometimes these services are partially funded by government. They are operationally dependent, however, upon the dedication of volunteers. Funds provided by government go more towards the hiring costs of full-time staff and administration, but they seldom, seldom go to those who supply the time and labour to make the services a success.

In the legislation, Bill 173, the services which the MSA is going to provide, as listed in subsection 2(4) and described as "community support services," are almost entirely offered by volunteer groups. A few may be provided through funded government programs, but not many. Most of those listed in subsection 2(5) are provided by home care, but not all. Friends and neighbours also do a lot of these, as with those in subsection 2(6). It's only those in 2(7) that are offered predominantly by professional service providers. But the government intends that all these services will be provided through the multiservice agency, as expressed in subsection 12(1). It isn't stated, but it's implied that the government expects that volunteers will continue to provide these services. I would ask you, is this a reasonable assumption?

It's estimated, for example, that there are 75,000 active volunteers involved in providing those services which come under the long-term care system. It's difficult to get a measure of the amount of time that volunteers contribute, but the value of their service must surely amount to millions of dollars. The loss of even a portion of this will be felt both by the MSA as well as by the clients in need.

What are the special features provided by volunteers? I would suggest to you that they are generosity of time; enthusiasm for the endeavour they're involved in; they are truly, to use a very bureaucratic expression, results-oriented; and the final thing about volunteers is that they're extremely intolerant of administrative practices. This came very clearly home to me when I discovered the number of volunteer charitable organizations that

annually lose their "charitable" status. Volunteer organizations do not do very well in meeting the requirements of Revenue Canada for retaining their "charitable" status and they frequently get into serious trouble in losing their "charitable" status.

While the government can provide funding to purchase care, the volunteers bring something very special to their contribution: They bring caring. They do more than provide care; they provide that care in a caring fashion. I'm not saying that this does not come through the service providers. I think it does, but the one feature, the one characteristic of all people who are involved in volunteer work is that they do come from that foundation of being caring.

What is the motivation of volunteers? Volunteers who freely give their time are motivated by factors which cannot easily be defined. They certainly involve a commitment to the organization to which they belong, but this is a fragile relationship which can easily be severed. When the commitment is related to the independence of volunteers, and this is one of the very strong features about them, the strength of the tie can be seen as tenuous. Volunteers expect to get some personal satisfaction from their association with their organization. They must feel that they belong, that their services are valued, that they can see tangible results of their efforts. Will the restructuring and the transfer to the MSA have an adverse effect on this relationship? Will volunteers be able to build up an allegiance, as they have done with their own organizations, to the MSA?

Managing a volunteer group is much more difficult and complex than running a small enterprise. In the management spectrum of volunteer groups, there's no place for control. Direction and instruction are secondary to the independence and therefore the personal wishes of volunteers, and that's always the critical factor in managing a group of volunteers. The wrong suggestion can very quickly disenchant a volunteer. A volunteer group is a most sensitive organization. Emotions can, at times, run high. Is this the sort of arrangement suitable for an MSA?

0910

Finally, funding, and this subject, I'm sure, will be addressed much better by organizations like the United Way, but many volunteer groups are funded either through citizenship, through Comsoc or through the United Way. Currently, in our community the United Way supports a number of volunteer groups. The question has already been posed whether the funding provided by the United Way will follow the volunteer group to the MSA or whether the contributors to the United Way will raise an objection to the use of their funds going to the government agency. Time will tell.

By going through the allocation of funds from our United Way, about \$500,000 on an annual basis goes to funding volunteer groups. If Bill 173 is followed through and comes into form the way it now exists, the United Way will have to make a decision of whether that money is going to go to the MSA or whether it will be reallocated into other areas.

It is my suggestion that volunteer groups remain outside the MSA and continue to retain their independent

identity. I think to some extent, if it is the intention of the minister, it is pretty outrageous to presume that volunteer groups will readily move over to form part of that organization. There will still be an enormous drive to make that contribution to society, but it will be the way in which it's made.

I don't really think, from the documents I've seen that have come out of the government or in this bill, that the government really understands the complexity and sensitivity of what it intends to take over with these volunteer groups. I think it's at risk of destroying something. I would suggest to you that it would be advisable to leave the volunteer segment out of Bill 173. Thank you very much.

The Chair: Thank you very much, and we'll go to questions with Mr Wilson.

Mr Jim Wilson (Simcoe West): Thank you, Mr Heasman, for what I think is an excellent brief on behalf of volunteers. I just want to make a couple of points that parallel yours. I would certainly agree that volunteers are intolerant, to a certain degree, of administrative practices. You mentioned the forgetfulness at times to adhere to Revenue Canada regulations, and I'll tell you, from the provincial side, we regularly have to reincorporate volunteer agencies under provincial statute through private bills. So it's a frequent occurrence at Queen's Park, and 99% of the time it's simply exactly that. Somebody either wasn't aware of the requirement or had other things to do and wasn't about to spend time filling out the forms.

I think you're right in your final remarks when you talked about the government perhaps not understanding the complexity and sensitivity of volunteers and volunteerism. We've heard from government members in this committee, when this topic has come up, that the government does understand and the proof in the pudding is that the government gives out awards every year to volunteers, you know, that there are a number of provincial awards and ceremonies that take place. But, just to remind the government, those people didn't volunteer for the government. They volunteer first for some organization or agency in their local community and the government comes along after that fact and gives them a nice award. Many of them, all of them I think would continue to volunteer, whether or not the government gave them recognition.

Your most important recommendation is to keep volunteers outside of the MSA structure. My opinion would be, as this bill is currently drafted, that would be impossible. Remember, there's pressure on the government from unions that volunteers actually take unionized jobs, and in essence, a lot of this bill is simply a unionization drive; it's to throw all service providers under one umbrella and unionize them. I agree with your contention that it's not really about services, and we intend to vote against the legislation. Do you think, in your reading of this legislation, that it's salvageable to meet your objective of keeping volunteers out?

Mr Heasman: Yes, I think Bill 173 is salvageable. There's no question of it. I think there are parts of Bill 173 which are excellent. It is a very remarkable piece of

legislation. I think it probably will be seen in hindsight, if it can be brought to that, as a masterpiece of legislation, but certainly I think there has got to be far more consideration given to many of these factors. I don't accept that point about the volunteers and the unions. There is plenty of room for everybody. You just talk to any volunteer groups and you'll find that there's still room for more volunteers. There's plenty of room for volunteer work. There's nowhere near enough of it and it's particularly in that area of the caring matters where real sensitivity, where empathy, where kindness is important.

The unions, rightly, are concerned with jobs, of people having tasks to do and for which they are paid, and reasonably well paid. I could expand tremendously on some of the things I think I would like to see put into 173. I'd like to see mandated benefits for those dedicated people who do home support work. I think many of those people who are single mothers, who are mothers on welfare who go out and do that tremendously important work in helping the elderly, the frail and the handicapped in-home, I think it would be a tremendous thing if Bill 173 put in mandated benefits for those people.

There is a government program which I would commend to your attention. You probably know about it, the program called Good Neighbours which is funded by Citizenship. That's a piece of legislation which I think again is remarkable in that it's encouraging people, it's encouraging a behaviour of change and I think somewhere in here on 173 and long-term care services we need something like that. I've given you a lecture, I'm sorry.

The Chair: Thank you very much for that, but thank you in particular for talking so forcefully about the role of volunteers, and we thank you for coming from Sarnia.

PERTH COUNTY LONG-TERM CARE PLANNING COMMITTEE

The Chair: I call the Perth County Long-Term Care Planning Committee; Sandra Hanmer. Welcome to the committee.

Ms Sandra Hanmer: Thank you very much for the opportunity to speak before you this morning. I'm very pleased to be here on behalf of the Perth County Long-Term Care Planning Committee to address our issues and concerns regarding Bill 173. I also am aware that the committee has convened earlier than originally scheduled this morning in order to hear additional presentations, including ours.

Just to give you a little bit of background, the Perth County Long-Term Care Planning Committee was established in November 1993. Our responsibilities include identifying and analyzing the needs related to seniors and people with physical disabilities in Perth county, establishing key planning priorities, developing a multi-year, county-wide plan to address strategic planning and service needs and to prepare a local implementation strategy for long-term care.

The implementation strategy will look at such things as service expansion and enhancements, the equitable distribution of resources and how a multiservice agency or multiservice agencies will evolve in Perth county.

Attached to the brief I've given you this morning is a list of the membership of the Perth County Long-Term Care Planning Committee. Also in way of background, the Huron-Perth District Health Council was established in June 1994. As I mentioned earlier, our planning committee was put in place prior to the establishment of the district health council in order that long-term care planning could proceed without delay. We have been resourced directly by the Ontario Ministry of Health through this process, in the absence of the district health council, by the London area office. Now that the district health council has been established, a member of the council has been appointed to our committee as a liaison.

Extensive long-term care planning in Perth county has been taking place for the past two and a half years. Five local long-term care planning committees exist in the natural communities throughout Perth county. These local long-term care planning committees all have representation on the county-wide committee. When our committee was pulled together in the fall of 1993, we were given a very strong message from the community. We were told that in planning for long-term care services, it is fundamentally important to build on the strengths that already exist in our county, and also that our planning process must be open and participatory.

Ideas we'd like to carry forward in terms of our discussion of Bill 173: People who do not actually sit on the long-term care planning committee must have easy access to it and must feel that they have a voice and are influential. We were very fortunate to have an opportunity on May 31 to present to Karen Goldenberg our recommendations and issues regarding MSAs. I have included this information to you with our briefing.

A great deal of support exists in Perth county for the long-term care reform objectives outlined in the legislation and in the compendium. The concepts of easier access, consumer centred, less assessment and services that are well organized and well coordinated are well received by both our planning groups and communities.

Concern has been expressed, however, with regard to the impact the multiservice agency may have on voluntarism. Many services to seniors and persons with physical disabilities are delivered by volunteers. Our volunteer base has been established over many years. People in small communities want to be able to support one another. We are concerned that the establishment of the MSA may mean the end of community-based agencies and volunteers.

0920

We think it is important to foster the concept of a multiservice network as opposed to a multiservice agency. The term "multiservice agency" conjures up an image of one single, very powerful central body as opposed to something that is grass roots, local, community owned and operated, flexible and movable. It is for these reasons that strong support remains in Perth county for an integrated model including a brokerage concept. While different models for service delivery may work in different parts of Ontario, it is our general impression that the limit of 20% purchase of service may be too small and could have a damaging effect on the future of service

delivery in Perth county. In reviewing the legislation, we are unclear as to the process for the appointment of board members for the MSAs. Will they be appointed by the minister? Will they be appointed by a provincial order in council? We strongly feel that the mechanism for the appointment of board members needs to include local input, as provincial appointment of board members would not foster local ownership and local accountability.

On the issue of accountability, who is the MSA accountable to? Is it accountable to the district health council? Is it accountable to the Minister of Health? What is the relationship between the MSA and the local district health councils? What is the relationship with the ministry? This all must be very clearly defined.

In addition to its planning responsibilities, this legislation also appears to be giving fiscal responsibility to district health councils. If this is the case, is the infrastructure required in place to ensure success? Are district health councils going to be, and do they want to be, money managers as well as planning bodies?

Perhaps some of the questions I have raised will be answered in the regulations that will follow the act. It would be very helpful if we would have an opportunity to review both the act and the regulations so that we could not only review policy but also the procedure and practice to be put in place. The appeals process appears to be somewhat cumbersome and time consuming. It's important that a local appeal process be clarified. How will the Health Services Appeal Board function? While the appeal process appears to be comprehensive, it must be expedient and efficient.

In closing, I would like to say on behalf of the Perth County Long-Term Care Planning Committee that it's unfortunate we had little time to prepare for the presentation. We feel with more lead time we would have been able to provide a more comprehensive briefing.

The next four years are going to be very challenging as we work towards fully evolved multiservice agencies. We fully support the flexibility demonstrated in supporting the concept of transitional models. We are still concerned with the final vision contained in the document. It's difficult to know what the service network is going to look like four years from now or as we enter a new century. We feel the single model of a fully evolved MSA as captured in this legislation may not be the best option or the only option for all areas of the province.

We still see a great deal of merit in piloting MSA models throughout the province. If this were ever to become an option, Perth county would indeed be most interested in participating. Our planning committee likes to look at issues in terms of what we like, what concerns us about the issues and, given the opportunity, how we would fix what concerns us. Bill 173 is a good start towards integrating long-term care services, and I hope my presentation has given you some ideas which will make it even better. I'd be very pleased to answer any questions. Again, thank you for the opportunity.

The Chair: Thank you very much for the submission and also for the various attachments that you've included.

Mrs Karen Haslam (Perth): I know a lot about Perth

county for some reason, and I know how hard they've worked. I think they need to be commended for the type of planning they've done even before the district health council was put in place. I think that shows the importance of the volunteerism and the type of people we have in the county that they do that kind of work. I keep touting Perth county as a very good model when we talk about our natural areas and natural patterns in Perth county and how that's come together and the type of care they want.

In think it's important, though, to hear about two things: number one, rural issues. This is an opportunity for you to explain how difficult offering some of these things can be in rural communities. Because we're looking at two counties now being together in a district health council, Perth and Huron, and they're both very rural ridings. I notice that you're working towards maybe an MSA network and maybe you could talk a little bit about what that would include and how that helps in rural areas.

If you get a chance, you could throw in an idea about how we could keep volunteers involved in the MSA. Maybe you have a suggestion about coordinating or what might work. I know the type of volunteers we have, I know the kind of people we have in Perth county and I know they will be volunteering because that's the kind they are. How can we help them in the MSA?

Ms Hanmer: Mrs Haslam has asked very many questions. I'll try and answer—

Mrs Haslam: Listen, when you're only offered one, you get them all in there.

Ms Hanmer: You get them all in. I'll do my best to answer them. Perth and Huron counties are indeed very rural counties. In terms of planning service deliveries, we've had to look at different models of how we can reach out to all aspects of the county. A single MSA housed in a large centre—with Stratford being probably the biggest city in the two counties—will not work from a service delivery standpoint for us. There are very different needs between the city population, and even the five local planning areas I've spoken of are different in size and different in composition. We need to make sure that whatever model we put in place will allow the services to be delivered to the local people who are going to be using those. In some cases, it may even mean going out to small hamlets and delivering service in that aspect.

So the long-term care planning committee is looking at various models. Different things, such as one umbrella MSA comes in mind, with a number of delivery sites, maybe four or five delivery sites. We have a good, strong brokerage model working in place now for service delivery and we'd like to be able to build on that. Services need to be able to move out.

In terms of volunteers, we have a very strong volunteer base and our concern with the volunteers being swallowed up by the MSA, we'll lose some people who are dedicated to perhaps the Lung Association or through other things that are sponsored by the United Way. If there is a mechanism that people can still feel an affiliation to their particular group but yet provide overall service to the county, I think we'll go a long way to be

delivering that. And whether it's through the establishment of one volunteer coordinator, similar training, similar orientation, a volunteer bureau where people are registered in one spot, but their own views and their own areas that they'd like to be participating in are kept in mind.

I think there's lots that we can work together but I think it's important that the committee take a look at the different geographical areas throughout the province, and models need to reflect that. The Metro model isn't going to work in a rural community. I hope that addresses some of your concerns.

Mrs Haslam: It does, and I think it shows very clearly why we're on the front of what we do in Perth county, because we've very good people there. Thanks.

The Chair: Thank you very much for coming before the committee this morning, we appreciate it.

0930

THE LAMBTON ALLIANCE

The Chair: Our next witness is from the Lambton Alliance. Welcome to the committee.

Mrs Joyce Anderson: I'm very pleased to be here this morning. We're from the Lambton Alliance. With me I have Jim Larocque. He is the chairman of the Lambton Senior's Association which is closely affiliated with the Lambton Alliance. I am Joyce Anderson. I'm a farmer from near Bridgen and I've been involved with the alliance since its inception two years ago. I'm the chair of the alliance. I come to the alliance from the women's institute. The alliance represents 60 seniors' organizations in Lambton county as well as women's institutes, super-annuated teachers, and retirees from Dow and Polysar.

The alliance was formed in order to study the long-term care reform redirection two years ago, and at that time we held dialogue groups throughout our county. We made a report and recommendations at that time on what we felt needed to be done in the long-term care system. We just happen to have brought a copy of those along today. If you're wanting that later on in the question period, we have it available with us.

We're really pleased to appear on behalf of Lambton people as consumers and we've been following the dialogue groups that have been held locally in our county. We have some overheads to assist you in understanding our presentation and Jim Larocque will man the overhead.

In our consultations two years ago, we found there were several things that had turned up in Bill 173 and we're very pleased to see that there are areas of agreement. We're very much in favour of the single point access.

We'll start on accentuating the positive. Okay. We really like the idea of the single access point. We feel it's really important that we be able to get information, referral and evaluation as well as assessment at that local point under the MSA. We think that's a really good idea, but we're quite concerned about all the other services having been lumped in there as well, which will make it a very large, unwieldy organization and you'll be buying and selling from yourself and it'll eliminate the competi-

tion idea. We're very much in keeping seniors in our home. That's something we've found from surveys in Lambton county, that seniors do want to be in their home, but we want quality life in our home and we want it to be cost-effective. If it's more expensive to stay in your home than an institution—we're very practical. We feel it should be the cheapest method approach rather than staying in the home at all costs, and a quality life is an essential if we're going to be left in our home.

Elimination of duplication: We know there are things in the system where there's duplication but we do believe that some duplication is necessary in order to have competition. If you haven't got more than one point to access different things, then competition is eliminated and there's no way of setting a market price. When there's competition, you tend to get better service because people know there's somewhere else they can go. The other thing with consumers, if you're frail, you don't want to have a hassle if you don't like the service. It's much easier to cancel service at one provider and change to another than it is to hassle and try and straighten it out where you are. We picture in this MSA, the one-stop shop where everything's provided, there really wouldn't be another alternative if you were unhappy with your service.

Turning to our concerns, we feel that the MSA services will create a large, monolithic bureaucracy. We love that big word. We picture that from the legislation—it says 80% provided by this bureaucracy, and from the list of services, it takes you two pages to list all those mandatory services that it says are going to be done. When it's doing this, it's going to require a lot of administrative staff to administer all those services and to organize all those workers. Currently in our county there are over 20 agencies providing those particular services and they've developed on an as-needed basis, so the people in them are very involved and include volunteers. Some of them are union people, some of them are non-union workers, and if these are all lumped together under one place, who's going to coordinate how to manage this labour mess of the people who have been receiving different rates of return and volunteering? It's going to end up appearing to us that the government's going to have to pay all of them, and probably at the price of the person who's being paid the most now. They're not going to go and make them all volunteers.

There are very diverse services and a large staff. That means it needs a large administrative staff, and in very large organizations, you get a distancing of the workers from the administration and from the general purpose. So you get alienation and you get workers who aren't getting full communications like you do in our current smaller agencies' operation. You lose the team spirit. It can always be lost that way in any very large organization.

Elimination of private agencies: We're very concerned with putting a number on that capping. We feel that the most cost-effective, most efficient service should be the criterion rather than putting actual numbers in the legislation. With the private agencies, there's still consumer choice. Not-for-profit is not always the cheaper alternative.

In our brief on page 9, item 3.5, you'll notice we gave an example about foot care. In our particular county we found that this was quite a startling piece of information that foot care—the last paragraph right in the middle of the page—cost \$9.70 from the private provider, whereas it cost \$37.50 from the other provider, that is, the not-for-profit. Of course, we know the private provider is also getting a profit, so just to say that we want to put all our money into health care and make it not-for-profit so that we're going to be getting the most bang for our buck doesn't always prove out to be that way.

The loss of consumer choice: The consumers are going to be responded to by having competition there. If you're the only one providing the service, it's very easy to sit back and not jump to it and provide what this consumer actually wants. We feel that consumers need to be able to have an alternative so that if they don't like the service, there's someone else.

Loss of volunteers: All of the agencies in our county providing service now depend on volunteers, and we can't see these volunteers volunteering for a government organization. They're affiliated with the VON or Red Cross or cancer or Alzheimer's because of a family member, or there's something in them that clicks that makes them want to help with that particular service. If it's all lumped together in one big agency, we can't see it being able to draw the volunteers or keep the volunteers. Some of them are very tired and they're going to welcome a chance to say "I quit." If the government has to replace all that volunteer labour, it's going to be very costly.

The charitable funding: Also, many of those agencies depend on charitable dollars. Many of them operate on funds that come from organizations that just raise funds, such as the United Way, and we can't picture the United Way being able to raise the kinds of funds it does now if it was to donate it to the government.

The only mandatory services that we feel should be provided by this MSA is the one-stop access for information, assessment, referral and evaluation. It should eliminate the duplication in the agencies through improved communication links and through improved assessment tools. In this day and age there are computer hookups and the information network. All the fancy information highway stuff is available that could be interrelated between the current agencies to improve the communication, without having to eliminate all of them.

Don't put a cap on the for-profit sector. Allow existing suppliers to continue to supply under their own names, and that way we'll be able to keep their management and their volunteers and their resources. The big MSA as inferred in this document will have difficulties with blending the labour force. There will be loss of morale; it will create uncertainty. People even now are worrying about job loss: "Are we working for the right agency?" We fear that there's going to be a loss of volunteers and definitely a loss of charitable giving.

In choosing which agency provides services for clients, we believe it should be judged strictly on qualification of the staff, the total cost and the quality of service.

Thank you very much for listening to our presentation.

0940

The Chair: Thank you very much, and we'll do the questioning with Ms Caplan.

Mrs Elinor Caplan (Oriole): Thank you for an excellent presentation. I have a fairly long history with the beginnings of long-term care reform, and the desires of all of us who've been involved I believe are to see that people get the care they need when they need it, in the community wherever possible, to allow them to stay in their homes and to be independent. So this piece of legislation is supposed to begin the development of that kind of system.

I have some concerns about it because the points that you've made as to the type of model that you'd like to see remind me very much of the original plans for what was then going to be called a single-access organization as opposed to an MSA. The original view was that there would not be overall service delivery by one organization but more of a brokerage model.

The question that I have for you is—and you've obviously thought about this legislation quite a lot. You've identified some areas where you think this legislation, if amended, could be fixed, and I'm wondering if you could just itemize and identify for us the specific areas you've mentioned, such as the removal of the 20%. Do you think perhaps instead, if there was a principle added to the legislation that required, upon evaluation, that as part of the brokerage model there be a test of who can provide the best and highest quality service at the best price, that might lead to the kind of competition or balance? Is it possible to include that in the legislation?

Second, what are the other areas specifically that you think could be amended to reflect your view that the MSA should be for the purpose of assessment, referral and in some cases perhaps information sharing and case management? I know it's a big question, but I'm looking for points.

Mrs Anderson: Okay, in reference to the 80-20, and you mentioned about the brokerage model, we've learned that we're misspeaking when we think in terms of brokerage model. The buzzwords in the Ministry of Health are that a brokerage model means that you call a point of access and they give you a list of phone numbers and, "Go to it, fella." That's not what we mean as brokerage, but commonly a lot of us think that term means that.

So what we're asking for is a purchase-of-services model. In that case, like you say, we believe it's really important that we have what's the most cost-efficient and effective. We want quality service at the most reasonable cost.

Mrs Caplan: I appreciate you defining the difference between a purchase-of-service model and a brokerage model because I think sometimes the words are used interchangeably. The protection that a purchase-of-service model would give to the consumer would not only be choice but it would safeguard the role of volunteers. In your opinion, is that where the strength of that would come in?

Mrs Anderson: Yes, we feel that's a great strength because it would allow the agencies to retain their present structure pretty much. If they're already providing the service on a volunteer basis or volunteer combination, then that could stay in place, but if it's all put under the one structure, I can't picture someone who's volunteering being quite happy to work alongside a union person doing the same thing, because right now many of these agencies use volunteer coordinators.

But when you get into something larger, you're going to have to have a paid volunteer coordinator. And it's going to make it harder to access those volunteers, because these smaller groups have their ears into the smaller community and the community as a whole in order to attract volunteers to their subject area.

Mrs Caplan: I want to thank you for an excellent presentation.

The Chair: Thank you, again, very much for coming before the committee this morning.

DO-R-BEST WOMEN'S INSTITUTE

The Chair: If I could then call upon the representatives from the Lambton women's institute. We welcome you all to the committee this morning.

Mrs Mona May Thompson: Good morning, ladies and gentlemen. I'm Mona May Thompson. I'm the program coordinator for the Do-R-Best Women's Institute, which is located in south Lambton in the community between Brigden and Oil Springs, if that helps to locate us any better.

Our organization is 61 years old, and in that time period we have been involved in matters that would improve education, agriculture, health and environmental issues and we have helped to promote women in growth and in their individual development. Our membership ranges from age 24 to 90, so we're very diversified in our ideas. Some of our members live outside our community now in Petrolia and Samia as well.

Also present today we have our secretary Mary Louise Piggott on the end here, and present also in the audience is our president-elect for the Federated Women's Institutes of Ontario, Margaret Harris.

The Do-R-Best institute became involved with the district health council two years ago when the dialogue groups were held around Lambton county concerning the long-term care redirection. Members of our organization at that time were part of the facilitating people.

To present our brief today I have Mrs Helen Havlik. She is the past director of nursing at Charlotte Eleanor Englehart Hospital in Petrolia. She is also at the present time chairperson of the Lambton County Association for the Mentally Handicapped and she is on the executive of the Lambton Alliance. She comes highly qualified to do our presentation on the district health council's relationship to the process. I'd like to present Mrs Helen Havlik.

Mrs Helen Havlik: Good morning and thank you very much. I am pleased to be here as well. We are in favour of the legislation in terms of its general direction and its overall purpose. However, we would like to point out that perhaps at this time it would be appropriate for the Ministry of Health and the government to look at

district health councils, how they are structured, how they're mandated, what their purpose is, how they flow information back and forth between themselves, their community and the government. Therefore, we would look at them.

In the legislation you have stated—you have put district health councils there but sort of, it seems to us, as just an afterthought perhaps, just a couple of paragraphs with respect to them. We would suggest that this would be an opportune time to actually put them in the legislation, which I think you have done, but also to state there what their purpose is, how they will function and how they will represent the communities they operate in.

We believe that up until the present time, although we understand there are some task forces in place and we've read some of the briefs on that, there is a change in the purpose and the methodology that they're to use. We think the legislation should reflect that. We think the legislation should have their purpose stated in the legislation and not just be perhaps a direction that's given to them from the Minister of Health. But it should be in the legislation, the purpose of the district health councils.

We understand that their membership is reflective of or should be reflective of their communities. However, I think that it doesn't state anywhere that they are responsible to those communities or that they should represent the views of those diverse groups that they represent on their councils.

So we would ask that some points in the legislation be altered to reflect those ideas: the purpose, the mandate, the structure and how they communicate with the people they serve.

0950

I think that this would serve the government well too, be a channel for people in the government to understand where the communities are coming from, and then certain things would not be imposed sort of from on high. The Toronto model would not necessarily fit the Lambton model, and that sort of thing.

We found, after all of our talking and so forth, and as some of the other presenters have shown, that when the legislation came back it contained things that didn't seem to have been in the dialogue that took place at the community levels. So this would avoid some of that happening, if the district health councils truly represented the views of the community, the membership that they have. We would ask that you look at the legislation as it pertains to district health councils and its very specific numbers. We would suggest some changes to that.

Under section 62, part XII of the bill, section 8.1 of the act, "The Lieutenant Governor in Council" and I won't read all of that. We say that we agree with that clause except that the permissive "may" is used. This implies that it also may not. I understand that was probably put there to give you some flexibility so that at times you may not want district health councils and you may get rid of them. But we feel that they are an essential component and they should be legislated. It should not be "may," but it should be that they "will."

The Chair: If I might, Ms Havlik, there is time, if

you want to get on the Hansard record, to read in some of those things. We're okay in that regard, just to make your presentation complete.

Ms Havlik: I'll start again then and say, "(1) The Lieutenant Governor in Council or the minister may establish district health councils and may specify the geographic area for which each district health council is authorized."

As I said, we agree with that except that we're a little concerned with the permissive "may" in that this also implies that it may not.

"(2) The members of a district health council shall be appointed by the Lieutenant Governor in Council or the minister." We agree with that.

"(3) In the selection of persons to be appointed under subsection (2), the Lieutenant Governor in Council or the minister, as the case may be, shall consider the importance of ensuring that the membership of the district health council reflects the diversity of the population in the council's geographic area." We would like you to add to that, "and these shall represent the interests of the diverse groups." In other words, that when they sit on the council, they're there to represent the interests of the diverse groups that they are called upon to sit on the council for.

"(4) The functions of a district health council are,

"(a) to advise the minister on health needs and other health matters in the council's geographic area...."

We agree with that.

"(b) to make recommendations on the allocation of resources to meet health needs in the council's geographic area...."

We agree with that, but I think we want you to say perhaps there that the regulations are required in that section. We understand that you can't put the regulations or the rules in the legislation, but if you would even point out in there that regulations will be required.

"(c) to make plans for the development of a balanced and integrated health care system in the council's geographic area...."

Guidelines as to how to plan and gain consensus are required in that area as well, at least to state that either regulations or guidelines are required.

In (d), reporting mechanisms to the community are required in this section. We have changed (d) and asked for reporting mechanisms to be worked out there. Work is being done in this area by the joint Ministry of Health/district health council task force. We ask that the legislation reflect regulations or guidelines which should be developed to address this function. Expedient completion of this work is encouraged. We understand there is a task force working on that, but we really feel that (d) should state that regulations about reporting mechanisms will in fact take place.

Under (e)—that was formerly (d) in the legislation—"to perform any other duties assigned to it under this or any other act or by the minister." That would become (e).

Then with (5) and (6), we agree with those areas.

There are other points. We actually suggest what the

purpose of the district health council should be, the structure and mandate. That's all in the brief, and the funding allocation and local autonomy.

The Chair: Again, if you want to put that on the record, that's fine.

Mrs Havlik: All right. Maybe I'll read the part under suggested changes.

We suggest that changes be made to Bill 173 which more definitively address the role of the district health council regarding its purpose, structure and mandate, as well as indicating which areas will need regulations.

(a) The purpose: The purpose of the district health council is to provide the government—the Ministry of Health—with long-term planning, implementation, process planning and measuring the effectiveness of programs and services of health care systems at the local level. The district health council will use Ministry of Health overall policies, standards and guidelines to produce this health care system.

(b) Reporting to the community: The district health council should reflect the will of the community it serves and should report regularly to the community at large, and we don't mean by that one annual meeting. Mechanisms for how this is to be done should be legislated.

(c) Regulations on resource allocation: Regulations are required which will assist in prioritization and the allocation of resources based on work that has already been done, and we refer you to the Comprehensive Health System Planning Commission of Southwestern Ontario.

(d) Prioritizing needs: Regulations are required regarding how prioritization and consensus are obtained, and this should be stated in the legislation.

Those are our areas of concern and our recommendations. Thank you. We're prepared to answer questions.

The Chair: Thank you very much for a great deal of specific work on the bill. We appreciate that, and we'll turn to questioning.

Mrs Dianne Cunningham (London North): Thank you very much for your presentation today. My feeling is that you've been involved probably since the 1970s and you have quite an extensive knowledge and work in a very important hospital to our region.

I would like to ask a question because I too have been involved when the health councils didn't have the same, I suppose, numbers of people working for them, and I think one of the great concerns the public have is that health dollars are in the front lines as much as possible, with people who are taking care of people. We're hearing a lot of the concerns about health councils, and we're wondering if one of the reasons for your recommendations is that you may feel that in some areas of the province, they may have gone too far. They may have too many resources. Most would consider it administrative. In your recommendations for change here, will that really take care of the balance, or in the mandate itself how are we going to balance administrative costs and front-line costs, taking into consideration your concerns about the health councils?

Mrs Havlik: The problem is that there's a lot of expertise in volunteers in this day and age now in the

communities which is not being tapped is basically what I'm saying. You have superannuated teachers, you have retirees from big corporations who have taken early retirement who are looking for work. They're looking for things to do, but they're not looking to be paid for it. They want to be kept active, they want to participate, and they want their minds to keep working as they have worked in the past. I think that in our county, by us being involved, by retirees being involved as volunteers, they have brought a great deal of expertise to the county for free.

Why not tap into that and at the same time improve their health, because if they don't participate in these things, they will lose their abilities, they will go and sit in a corner somewhere and deteriorate. So you're killing two birds with one stone, as we say. You are getting something for free, good stuff, and you are also preventing ill health of those people who are sitting out there looking for something to occupy themselves. I think that's the perspective we're coming from. Why not use the talents that are out there?

1000

Mrs Cunningham: So are you saying that the volunteers should be used on health councils as well as in the hospitals as we've known them in the past?

Mrs Havlik: That's right, and not just on the health councils, but in order to get the kind of perspective that the health council needs about the community, these people could help, and they would be unpaid staff. I realize that you need paid staff, and you said like the administrative costs, and of course there will always have to be paid staff. There would always have to be paid staff. We understand that.

We're not very clear as to how the resources have been spread out throughout the province. They may have been overloaded in some areas. I'm not totally knowledgeable about how that has taken place. But in our own county I could see where the administrative costs—yes, you have to have some. But try to keep them at a minimum and use these other people, and you will get help that you didn't even realize was out there.

The Chair: Thank you very much for coming before the committee this morning. I think, as it's happened, we've heard a great deal about Lambton county. There are obviously a lot of people in the county who have been doing a lot of work and we thank you for it.

PORT FRANKS SENIORS ACTION CLUB

The Chair: I call on Mr Ken Reffell. We welcome you as well to the committee.

Mr Ken Reffell: My name is Ken Reffell, and I reside in Port Franks. Port Franks is in Lambton county. A 10-minute drive north on 21 would get you to Grand Bend, and another 40 minutes, if you want to go southwest, will get you to Sarnia, and we're right on the lake. So this gives you an idea of where I'm coming from.

I represent the Port Franks Seniors Action Club. I'm a member. They wanted me to convey the fact that they support the objectives of Bill 173. They think it's an opportunity for them to look at other aspects of the community so they can get involved. Now, they are

involved with setting up tours and visits to hospitals and things like this.

If I can get back to the brief, on page 3, what was there was the words "open-ended," and that to me is a waste of money and was the wrong word because everything's there, gifts to take, and this isn't what we want. What we want is flexibility in funding.

There is a news brief attached to your package that you can look at in your own time, and I'll make a few remarks on it later on.

Well, good morning. Here we go. We do agree with the bill, as I said in the beginning. The ideas behind it are tremendous. When you read that section 1 and what they're trying to do, it sounds great, but then when you get into how they're going to do it, they don't mesh. There seems to be a lot of symbolism. The substance isn't there yet, and that's the thing I'd like to talk about.

We should design the system to serve the person, not the person to fit into the system, and what that involves is a choice, giving us a choice. And when we say choice, we mean a menu service, not just a rigid prescribed program, but we want it with a cap. We are concerned that the impact of physicians, for example—it's vital and it's not to be omitted from any stage of the assessment or the placement of that person.

If you would like me to give you just a short analogy of that paperclip—this is a factual thing. This isn't theory we're writing. We hope this works. This is a factual thing.

This lady has two tubes, one in her throat and one in her stomach, and every two hours she has to feed herself. She's just been advised that OHIP is no longer going to take care of that cost. Now, she's at home. She's able to live to the fullest of her life and it's in private and she's happy to do it. What they're saying to her, and a spokesman from OHIP said to her, is, "We're sorry, but we don't think you qualify for our help."

Now, they qualified that by saying: "If you join our home"—what shall I say?—"plan, then we can do this for you. If you don't want to do that, then you'll have to get on welfare."

So we're saving a dollar and spending \$10. They say, "We'll give you this, providing that you go through two other sources," but it's still government. It would cost less if she just continues to do it herself.

So this is one of the points I'm trying to make about having it flexible.

I'm going to split my time so you get as much time as I have to speak to ask questions, and this I think will work out for the best of all of us.

The appeal: I was really surprised when I looked at the appeal. It's just unsatisfactory. It's too long. It's 30 to 35 days, and we want it three days maximum. Most important is the fragile and ill older person not travelling outside their community. This appeal should be brought down to the community so that in three days we're taken care of.

For example, if she's going in the hospital for an operation, she comes out and she was supposed to be home for three days. She can't go on a waiting list

because it's going to cost a lot of money sitting in the hospital, or lying in the hospital.

We feel that if we have a flexible plan that can say, "Yes, we can look after you, and this is the way we're going to do it, at the most economical cost"—in that first section they say that we're going to get economical service, and we agree with that; it's when these economical services say, "Oh, no, we can't look after you," and they put you aside.

1010

I believe that another very serious part of that appeal board is that there's no human touch to it. In other words, suddenly you're not eligible and a phone call comes to you. We think a person should go out to that person and explain to them why they can't and how to get the appeal board working for you and so on.

We're suggesting that an appeal board have only four members, and not more than two should be medical personnel. There should be an ombudsman involved, an outside party, a third party, if you will, checking on the accountability of that board in relation to the condition of the person.

I think I've made my points, and if you'd like to take over the questions, I'd be glad to answer them.

The Chair: I just wanted to make sure there wasn't anything in your written brief that you hadn't said, just to make sure we get it on the record, because we do have some time if there was anything you'd like to add.

Mr Reffell: Oh, we do have the time? I thought I had seven minutes.

The Chair: No, you have 15. I just want to make sure you can get all your points out.

Mr Reffell: I cut them back for that reason.

The Chair: If there is anything else there that you wanted to include, you have a few other points there.

Mr Reffell: Okay. The available service and programs do not define consumers' needs. This goes back to my opening statement about, don't put the person into the service, have the service suit the person. This is what it means by it doesn't define the consumers' needs. It doesn't look after those needs. It's too rigid.

And flexible funding: That is, for example, that lady in London, Mrs Rowe, who has cancer and has all these tubes in her.

Another point I'd like to make is that multiservice agencies should help make other referrals on the appeal board, and service must be provided until the decision is made by the appeal board. We don't just leave the person somewhere waiting for the service.

A neutral facilitator is very important.

I think those are the points I wanted to make.

Mr David Winninger (London South): Thank you for your presentation. You seem to agree in principle with the single access point to an integrated continuum of services, but what I hear you saying is there needs to be more flexibility and consumer choice involved.

Mr Reffell: Yes.

Mr Winninger: You also seem to support a process

that is locally driven, locally planned, locally managed, locally funded and providing for delivery of services in a manner that's responsive to the community.

You're one of the first I've heard who has actually addressed the appeals procedure in any kind of focused way. I thought I'd note firstly, and then put a question to you, that there's nothing that I can see in the legislation that would prevent the MSAs from having their own alternative dispute resolution procedures or internal complaints procedures that might be able to deal with refusal of service or refusal of a particular kind of service, short of actually proceeding to appeal. So there is a possibility and potential there for a local resolution to a problem.

At the same time, I see some value in having a standardized form of appeal to the board, similar to that that prevails with nursing homes and homes for the aged, so that you can have some kind of consistent decision-making across the province which will offer precedents that people can rely on in the future.

I just wonder if that kind of balance between local alternative dispute resolution mechanisms and internal complaints, and yet a unified system of appeal to the board, would suit your concerns.

Mr Reffell: I think it's an excellent idea that you make, but I'd like to get accountability into that decision, an outside body. I think that if there is an excellent assessment tool in place, we wouldn't need this board at all. If we had professional, prudent decisions made, we could do away with it and save a lot of time and—

Mr Winner: One hopes that would be the model for the MSAs.

Mr Reffell: Yes.

Mr Winner: One other thing I noted, and you probably did too: Section 37 of the appeals section said if a person is unable to attend a hearing before the appeal board, at that person's request the appeal board members can actually attend upon the party requesting the hearing.

Mr Reffell: Right, absolutely. I think that's a good idea.

Mr Winner: Presumably the appeal board can be responsive to individual needs.

Mr Reffell: Well, if that is the case, yes. But it's the time element that's so important. If it's locally, it'll be three days, and if they're receiving the service then it can be five days. But we want it quickly, again. But I think the appeal board should be almost done away with if the proper tool is in place to make the assessment and the placement and that's done by professional, prudent decisions. This is an extremely important issue, I think, and one that deserves a great deal of thought and discussion.

The Chair: Thank you very much. I think, as Mr Winner says, you have really focused on that appeal procedure and we appreciate the points that you've made. Thank you again for coming before the committee.

Just before calling the next witness, members of the committee have also received a number of written submissions that have been sent in and the clerk has set out for you.

KATHY DESAI

The Chair: Our next presenter is from the Oxford county home care program. Kathy Desai is the director. The clerk is passing out a copy of your presentation. Welcome to the committee and thank you for coming.

Mrs Kathy Desai: Good morning. I am Kathy Desai. I'm the director of the Oxford county home care program; however, I don't have anybody's permission to represent them or be representative of them today. But I think that Mr Reffell and I will form a new group because I have exactly the same thing to say as he does. We haven't met one another, but we could have done our presentation together.

The Chair: I'm glad we brought you together.

Mrs Desai: I thank you for the opportunity to comment on Bill 173, An Act respecting Long-Term Care. It is with a great deal of optimism about an improved system, balanced with a nervous scepticism about the possibility of implementation, that I encourage you as a committee in this very necessary work.

In my view, the intent of the legislation is progressive and well thought out. It reflects a balance of academia, provider knowledge and consumer wisdom. There are, however, opportunities to improve the possibility that this intent will remain intact throughout the implementation. I hope to highlight some of those opportunities by organizing my remarks into three areas: concerns about the overall system of health and social service, the MSA itself, and the individual consumer.

The overall system: It is my belief that the single most important organizational concept in the reform is integration. The minister has spoken of a move from the broker model to the integrated model. Academics who have looked organizationally at long-term care believe that integration is the key to success. Through integration, efficiencies can be realized and appropriate use of various supports, services and beds can be made.

1020

The consumers want less specialization and fragmentation, which is more integration. To support the values of efficiency and effectiveness, we need to support integration. In the short term, integration is within the MSA, but the long-term goal needs to be greater integration along the entire continuum of care. The integration needs to occur first at the policy level and then at the service level. The most significant integration in this long-term care reform is the link the PCS will provide between long-term care institutions and the community.

The Chair: I'm sorry. Just for the record, PCS?

Mrs Desai: Sorry. Placement coordination service.

This will be the first real opportunity the community services have to provide an alternative to institutional care and the first real opportunity to reallocate dollars.

My issue here is that the integration does not go far enough. Short-term community-based care has no similar placement coordination services link to acute care hospitals, so envelope funding could lead to the erosion of long-term care. At the policy level, an integration of Bill 101 and Bill 173 etc, maybe the hospitals act, would set the stage for integration at the local level.

It is important for implementers of the act to understand the true significance of integration and the longer-term vision of integration, so I would argue that it should be written into the act, perhaps in the purpose and perhaps under 1(f) where we talk about efficiency. I believe it also needs to be understood that the comprehensive health organization is the most integrated model suggested and therefore has the greatest opportunity to be cost-effective across the continuum.

The MSA: The section of this act that applies to the MSA itself treats change as though it were a clear rejection of the past. However, it does not ensure that the future will enable individuals to be more independent with respect to how they solve problems.

By including persons experienced in the health services field and persons experienced in the social services field, as demonstrated in 11(b), you will encourage a balance of health and social assessment, and this is long overdue. It just is not good enough. Empowerment is an idea whose time has come, and it will happen. It will happen more readily if the structure supports the function.

All expert models promote learned helplessness, not just the medical model. The learned helplessness results from the attitude of the help giver and the deference to care giver authority of the help seeker. Past change did not go far enough or deep enough, and this does not either. Cutting out the past and having new people deliver the old will result in more of the same, only "new and improved." What we want is transformation that recognizes the past in the same way we recognize the present and the future. New attitudes develop with new information.

It does not matter what group becomes the sponsoring body for the MSA; they need to be empowered and they need to understand how to enable other people. They need to understand what structure will support professionals and others in using the appropriate models. The effectiveness outcome will be directly proportional to how independent the consumers are with respect to their own health, not what professionals are employed. The oppressed don't necessarily make any more empowering leaders than the oppressors. Everyone in the past, present and future model needs new information. The whole idea of interim MSAs needs to be thought through so that the encouraged development is consistent with the long-term vision of integration and empowerment.

Individual consumers: This act wants to ensure accountability to the consumer, but on every mention of the real client, there is an assumption that the help seeker is less powerful than the help giver. That is an expert model. That leads to dependence and learned helplessness. This is most obvious, as the former speaker pointed out, in section 20, the service plan, and section 32, the appeal. The purpose could also refer to accountability in a more real way, more directly related to clients, and I think Mr Reffell said that best.

Section 20 does not ensure a contract reflective of a partnership. To "assess the person's requirements," as it states, infers the expert is the help giver. An assessment tool will be rendered useless if it is not administered in an empowering way. It is how you do it as well as what

you do. We cannot cure; only the clients can do that themselves. It is the questions we ask and how we listen to the answers that becomes vital to matching needs and resources.

I don't want to sound overly simplistic, but number 3 in this section should be first, and the section 1(a) should read more like, "The person participates in the process of assessment, and the outcome of the process is a plan reflecting mutual goals." This is a contract. This is a partnership.

The whole idea of timeliness and a waiting list is pretty oppressing as well. If there is a CQI process that includes consumers, this needs to be individualized in the local MSA. I personally think waiting lists are a symptom of a system that does not know how to prioritize and a system that believes there is more money than there is. We need to be more accountable in defining need so there will not be waiting lists, rather than legislating waiting lists.

The language in the appeals section, section 32, does not reflect mutuality in the plan of service. It clearly allows the provider and/or agency to be the expert. It also infers that the expert opinion can be overruled by the superexpert. The goal of a client-driven model would be a mutual agreement, perhaps for disengagement from formal resources. This appeal process makes the agency accountable to the government rather than the person, and that is not transformation. I thoroughly support an appeal process. The wording is very challenging, but it has to reflect a partnership.

In summary, the policy direction is a good one. I'm very happy. It forces a new relationship between partners in in-home services. Together, the two bills link long-term care facilities to in-home services. The act removes the competition within the MSA so energies can be focused on the delivery of services. It also recognizes social as well as health needs. However, the issues of cost-effectiveness and quality of service are not sufficiently addressed. Cost-effectiveness could be enhanced by more definite language around integration as well as more horizontal and/or vertical integration. The quality of service could be ensured by making the agency accountable to the people it serves, or making it client-driven. The language in the act does not encourage transformation or even reform; unfortunately, it is *passé*.

Thank you very much for the opportunity. If you have any questions, I'd be happy to try to answer.

Mrs Caplan: I'm really impressed with the presentation you've made, Kathy, and pleased that you've come before the committee today.

I want to just explore with you a minute some of the concerns you have around the lack of integration within the proposed model, but also seek your advice. It seems to me that under the comprehensive health organization model that you referred to, or any other kind of an integrated model, direct service delivery is not the only option. In fact, there is an opportunity within that integrated model for purchase of service, which would allow for competition, best practices, benchmarking, cost-effectiveness. You didn't address that. What I heard was that you felt the MSA, as it is defined in this legislation,

as the sole provider, might be acceptable. Could you just expand on that?

Mrs Desai: I've tried to form my opinions about this related to Michael Rachlis's work and Carol Austin's work. As you know, I run an agency that is a case management organization, and I've tried to think of it from that perspective as well as from the cost-effective perspective. Everything I read makes me think—and this is different than I thought three or four years ago—that until there is one body accountable for the entire spectrum, you cannot realize efficiencies from the more expensive services to the less expensive services.

The way Carol Austin defines "authority" in case management is the breadth and scope, the scope and span, of the case manager's role. The least effective authority the case manager can have and the least effective efficiencies she can realize, then, are when she's just controlling contracts on a fee-for-service basis with providers. The most effective span of control she has is if she follows the client from entry to the system for ever, because then she has authority to look at utilizing the least expensive services first.

So I've come to think that competition has, in our mind, some value in controlling costs in the short term. But it currently is my view—but my view changes every time I have a new piece of information—that competition is not the most effective way to get efficiencies over the overall system. It's also my view that competition has in some ways held the community back. It doesn't exist in other areas of the health care system, and in some ways it has not enhanced our ability to improve community services.

1030

Mrs Caplan: Within that fully integrated model where you had the options as to how you would deliver, based on your philosophy, what sorts of outcome measures and evaluations would you use to ensure (1) the accountability, and (2) the fact that you were getting the most cost-effective? I ask that question because we have some models that suggest that when you have one big bureaucratic monolith, in fact it's less efficient and effective than it could be or should be.

Mrs Desai: This critical mass and how big you can be and still maintain a client-driven consumer focus isn't something I've totally sorted out, but it's a very critical issue in giving the interim MSAs the go-ahead, because if we're going to have a long-term vision of a comprehensive health organization, then you need to develop around populations that would be right for that. On the other hand, if we're not going to see total integration as our long-term vision, then it's quite a different population you would need. Whatever decisions you make now, we're going to live with for a long time, so I think we need a common perspective about whether we believe integration is the way to get efficiency or not.

In terms of this accountability, and this may be overly simplistic, but it's my view that if we did transform, if this reform is radical enough—and by radical I mean going to the core, so you turn your organization inside out; you begin to ask completely different questions of the client. It's not, "What is your past health history and

how do I match services to needs?" It's: "Who are you? What was your picture before you were sick? What is your picture now and what do you want your picture to look like in the future?" So if you begin to say, "Tell me your story," instead of, "What's your diagnosis and what services do you want?" it is my view that's accountability, and it's my view that would be cheaper than what we're currently doing, because the mindset of the provider goes to these minimums and maximums, and that's not where the consumer is coming from. If you ask them what they need—need and want ultimately in an ideal world are the same thing, but we do need a lot more thought right now about what need and want are, and if the consumers want more than we have to give them, then I would say they got that from the providers, so the providers have to take the initiative in changing that around. I mean, we've encouraged them to go for boxes because that's how we fund health care.

So turning it around, that accountability comes from really being client-driven. I'm not afraid of being client-driven if we really do turn the system around, but it's hard in the interim when you're half and half, when you need an accountability structure to control what we think would be uncontrollable costs and when you're trying to transform. I don't know if you can do this halfway thing, so I would say go for broke.

Mrs Caplan: Thanks very much. That was very thought-provoking and very helpful. You've raised a number of issues that I don't think have been raised before at the committee. How the system can be reoriented so that it is client-driven, with the patient's interests and the client's interests coming first, I think is ultimately one of the goals that I'd like to see as part not only of long-term care reform, but any health reform that is brought forward. Thanks again.

Mrs Desai: It was nice to have an opportunity.

The Chair: With the committee's permission, we have with us today also the member for Oxford and I'd like to allow him one question.

Mr Kimble Sutherland (Oxford): I don't really have much of a question. I think some of the questions Mrs Caplan asked pursued some of the areas. The accountability aspect was certainly one.

Let me just say that I'm very fortunate to have Kathy's advice on a regular basis as one of several providers who provide some very innovative thinking on where we should be, and I would suggest maybe out ahead of many of us on where our thinking is on how to deliver health and social services and the work to integration.

I guess my only comment is whether you wanted to address the issue—we certainly heard some concerns about how volunteers fit into an MSA model, in some sense that volunteers may be lost in that type of model.

Mrs Desai: I've worked for volunteer organizations in the past and I recognize the value that volunteers have to the entire system. Being in a community, I've always been jealous of the volunteers and the money that acute care institutions could raise in competition with us. I don't have any sense that volunteers would be any less active in a system regardless of how it's funded. Volun-

teers work because they want to contribute something, and it depends on how you recruit them; it depends on how you reward them.

Certainly, the volunteer sector has done a lot better job, perhaps, of acknowledging their contribution and it's been a much more obvious, innate part of the organization. But if you set it up right, there's no reason why volunteers wouldn't contribute to the MSA the same way they contribute to foundations, hospitals, whoever. It's all the same people working in the same community. It's how you treat your volunteers that keeps them with you, and how much satisfaction they get out of what they're doing. It's not what organization owns them. We should forget all this organizational stuff.

The Chair: Thank you again very much for coming before the committee this morning.

Mrs Desai: Thank you for the opportunity.

The Chair: Are the representatives from the Belle River and District Community Council here? No.

ANNE FOWLER

The Chair: Ms Anne Fowler is here and we can proceed with her presentation, and then should the Belle River representatives come, we can go back. I believe as well that the Victorian Order of Nurses are here, so we will go on to them next if the Belle River group is not here. Ms Fowler, thank you for coming before the committee.

Ms Anne Fowler: I sincerely appreciate the opportunity to speak to the standing committee on social development, and I speak to you as a consumer, a care giver and a case manager.

It is important to me that you consider my perspective as a consumer and care giver. I am the only daughter who lives in the city where my parents live and they are almost 80. My parents are alert, capable and independent and they cherish the dignities of privacy and autonomy. But during recent years, when one becomes ill, even for a short term, the stability of the situation is precarious and my responsibilities change drastically.

It is also important that you acknowledge my opinion as a case manager, as a person who has a unique perspective because of extensive experience working in the field facilitating access to community-based support and in-home services.

My life situation, including personal responsibilities and 25 years working in the health and social services system, certainly impact on my positive thoughts and worrisome concerns regarding Bill 173.

The legislation: It definitely has strengths. I commend the ministry on introducing legislation that reflects a shift of philosophical and service delivery perspectives. The attempt to facilitate access and to enable flexibility in service options that indicate a greater sensitivity to the person's needs rather than the system's rules are welcomed. The emphasis on client empowerment and self-direction are beliefs that have always been a guiding principle in my practice as a case manager. The intention to support the local district health council as the community leader in MSA implementation and decision-making is essential to ensure that this process is commun-

ity-driven. I acknowledge this legislation impacts considerably on the person's access to the system, a skilled assessment, an effective service plan and appropriate service options.

My concerns as a consumer: I support the emphasis on simple access and agree it can be approved, but I urge the ministry to take great care that the initial focus on perceived need and task does not lead to inappropriate and excessive assessments prior to appropriate service delivery. This would only increase the risk to the client and the exhaustion of client and care giver.

An example is a request for help with a bath. It sounds pretty simple, but in fact a home support worker or a nurse might be quite inappropriate in this situation. Maybe, on careful questioning based on a broad health needs knowledge base, it might indicate that an OT is required because there are environmental modifications that are required. Simple requests do not necessarily equate to simple need and simple solution, so do not underestimate the complexity of needs or the variables of your MSA target population.

I agree with the ministry's believe that different models of case management are required and that some clients or care givers wish to provide their own. I recognize that the "well" physically disabled may only wish to initiate annual contact or maybe none or maybe just involvement with problem situations, but one must realize the well person has greater energies and strength to focus on directing coordination activities.

The frail elder with health concerns and without family in town may wish regular contact, but this too is a model of self-direction.

I've met many care givers who are focusing their energy on supporting the client, and one more responsibility would be considered too many. As a consumer, I request access to components of service coordination to the degree that I determine.

Something else I wanted to say was there really, in my experience, has not been a public education program by the ministry to the citizens of this province concerning the health and social services system. They know about the nurse from billboards and TVs, about the physiotherapists in the yellow pages and at sports events etc. Many consumers know little about the human resources, including case management, except when they experience a system-generated service restriction. Misconceptions and lack of information mislead consumers and jeopardize the ability to determine the issues and to make decisions.

Now, my concerns as a care giver: I'm appalled that the case manager or service coordinator may be determined by the "problem" or the "need" of the month. I want to be able, as a care giver, to contact an expert in assessment and coordination. I want someone who is committed to building on strengths, meeting needs, advocacy, communication, linking and coordinating services.

The assumption that all service providers have the time and the expertise to focus on quality service coordination and to ensure continuity and to be available to the client and care giver is erroneous. Canadian-based research

evaluating this approach is not available. This assumption, transposed to other settings, infers that any teacher is skilled and knowledgeable to teach any student in any grade, or any engineer can work in any work setting. This thought process seems absurd. Why in the health and social services system is there the lack of recognition for the skills, knowledge base, expertise and role expectations in the unique and the different roles?

As a care giver, I don't have the time or energy to deal with system inadequacies, to search for the right answer, to ensure I'm asked the right questions and to get the right service provider. I expect the MSA staff member who connects with me via phone to have the skills to do this efficiently.

My concerns as a case manager: The ministry has neglected to include case management as a core service and again is demonstrating a continued undervaluing of the skills and knowledge required to complete this function well.

I have the utmost respect for service providers, specialists in their scope of practice. I value the skills, commitment and knowledge that community support, health care and social service providers possess. But to assume that all service providers have the skill, knowledge, interest or mandate to provide this unique role is folly. Many service providers emphasize the assessment of illness state and interventions re the diagnosis and disease process. And their expertise in this is valued. It is important not to misuse their time and specific expertise, a misuse that can only lead to escalating waiting lists.

There's no emphasis in Bill 173 regarding the collaborative efforts of community service providers—the team. All are accountable, but one needs to ultimately be responsible for ensuring a simple resource contact exists and that the smooth coordination of services occurs.

Fragmentation within the system will decrease and integration increase when the ministry more clearly defines approaches to access, assessment, service provision and also ensures that service evaluation, outcomes and cost containment are integral in these considerations.

So in summary, as a consumer, a care giver and a case manager, I acknowledge the system requires philosophical and organizational changes. I urge the ministry to recognize that simple service need does not equate to simple need; it merely means one service is maybe adequate for that day or point in time. I expect the right to access simply and quickly a holistic skilled assessment, continuity and consistency in the contact person and expertise in service coordination.

I recommend that access move simply and quickly from information-giving to assessment when need beyond clearly defined community support service is indicated; that the assessment be client- and need-focused from a holistic perspective rather than reflect task and specific clinical emphasis; that case management be listed as a distinct professional service.

I recommend that the decision to delegate the case management/service coordination function be made in consultation with the client following assessment that clarifies, with the client, the needs and the actual service

provider who is required. I urge the ministry to commit to a public education program that includes not only information about system changes and service availability but also about costs and the rationale for cost containment.

Thank you for this opportunity.

Mr Jim Wilson: Thank you for your presentation. You bring to light what many presenters have also brought forward to this committee: concerns about the assessment process.

I can tell you that we don't really know at this time—and are unable to really find out from government, because they're still looking at this area of, as you know—who or where or how assessments will be done or what the eligibility criteria will be. That, to be quite frank, does make it quite difficult for us as legislators to really make an informed decision about this legislation given that so much of it is not spelled out in the act, because assessment, as I think you'd agree, is the key to this whole thing. It's also the key to things like whether or not the particular consumer has to pay for certain services. When the plan of service is developed, it's absolutely crucial that proper assessment be done.

1050

So I'm just going to ask you to try in as simple a way as possible to give me your vision of what the model should be. I want to get that on the record. Particularly I'm interested in trying to picture how this will be done by the MSA: whether it'll be one person who takes the initial assessment and then the client, for various reasons, whatever they may be, is then referred to a multi-disciplinary team for assessment, or how will this be done and how will it be done within an MSA, given that a lot of these people are going to have to be on staff because of the 20% rule.

Ms Fowler: That's correct. I guess I can see it evolving actually fairly simply. I certainly have read the recent—and I must preface my remarks by saying I've read the most recent infrastructure working group documents related to the MSA, and in the last two weeks they have been dealing with service coordination etc. I have to say what's in those documents pretty well scares me as a consumer. I'm truly distressed, especially by the screening and the intake process that is being suggested. It's extremely convoluted.

I really think there can be a screening process that is extremely simple, and for the person who is well or even not well and clearly defines a need that's very specific and community-support-related, the actions may occur right then. But for the majority of the target population that I've had experience with, and I know within home care there are over 50,000 on every single day who are receiving in-home services that way, I think then it needs to move to a broad-based assessment. It's very intimidating to have numbers of people go into people's homes. One of the privileges in working in the community versus, say, the institutional sector where I have worked, is that nobody needs to let you in their door. They really have the right, and it's wonderful. That was one of the most liberating experiences I had in the community.

But I think one person with extensive skill could very simply do a broad-based assessment to establish what service is the real need for sure, and in consultation with the client. I can't imagine not feeling a partner with the client. In fact, they are the ones who should be in control always. I'd demand it as a client or consumer. I wouldn't tolerate any other kind of method of interaction; I just wouldn't. So I wouldn't think of treating anyone else that way.

But I think it can be done simply. I think there can be an initial screening and then go to a broad-based holistic type of assessment and then go immediately out to the specialists that are required. I think it would be great to have for consultation purposes a multidisciplinary team or a geriatric assessment resource. There's a variety of resources that would be helpful for that person to be able to consult, but I don't think the client in the home has to be intruded upon by numbers of people.

The Chair: Thank you, again, very much for coming before the committee. I would ask again if the representatives from the Belle River and District Community Council are here. Going once. Okay, we'll see; they may have been delayed.

VICTORIAN ORDER OF NURSES, SOUTHWEST REGION

The Chair: I ask the representatives from the VON if they'd come forward. If I could say to committee members, if they wish to do what I'm going to do, having been in the chair for a couple of hours, I'm just going to stand and stretch.

Mrs Caplan: Where's the music?

The Chair: Yes, we need the Blue Jays team, or something.

Mrs Haslam: Blue Jays? What are they?

The Chair: Down the road.

Welcome to the committee. We know that you are here representing a number of branches of the VON. For the information of committee members, by grouping a number of branches together, we're providing more time. We just thought that would make for a more concentrated presentation and perhaps allows us to ask a few more questions.

Thank you for coming, and if you'd be good enough just to introduce yourselves and then please go ahead.

Ms Janice McCallum: Good morning. My name is Janice McCallum. Sorry for the confusion on the agenda, but I am doing the presentation today. I'm the president of the Middlesex-Elgin branch, which is the branch that is located in London. With me is Kathy Bamford. I've been thinking about the things that Kathy Desai had said. They were quite provoking. Kathy Bamford is the executive director of the Oxford branch and she will help me with the questions, particularly related to anything in the branch program delivery area, but I will be doing the presentation.

The Chair: For the Hansard record, could you just note the VON branches?

Ms McCallum: Yes, I was going to go through the branches. The seven branches that we're presenting on behalf of today in a joint submission are the branches

from Chatham-Kent, Grey-Bruce, Middlesex-Elgin, Oxford, Perth-Huron, Windsor-Essex and Sarnia-Lambton. So there are actually seven branches and they make up the southwest region.

The seven branches of the VON of the southwest region of Ontario appreciate this opportunity to present their joint submission on Bill 173 to the standing committee on social development. You may be aware that VON has a 97-year history of keeping people in their homes through the provision of community health and support services. With this experience, we recognize the need for reform and we support the Long-Term Care Act's purposes and general directions.

Here's a little bit of background for you. VON is a not-for-profit, voluntary health care organization that addresses the health and social support needs of people in Ontario through services provided by nurses, other health professionals, home support service workers and volunteers. I'd like to add that VON is a national organization and we are chartered through VON Canada.

The county configurations of branches that we're representing today include the makeup of the southwest region. They coincide with the names I identified for the branches: Chatham-Kent, Grey-Bruce, Sarnia-Lambton, Middlesex-Elgin, Oxford, Perth-Huron and Windsor-Essex. Our 1,213 employees and over 2,000 volunteers service expansive and diverse communities from Manitoulin Island to Lake Erie, Lake Huron to Waterloo region. In 1993-94 we provided 767,000 nursing visits 24 hours a day, seven days a week to the local home care programs. Last year we delivered over 82,000 meals, we provided close to 30,000 hours of volunteer visiting and 12,500 adult day centre days for those in need, and those are only examples of the various services provided.

VON is founded on local volunteer community boards which oversee the delivery of services in partnership with local communities, clients and other providers. As a grassroots not-for-profit organization, we support local needs and collectively have networked to realize the benefits of standardization for efficiency and effectiveness. For example, VON Canada has assisted the branches by the development of program standards, and while some branches such as Grey-Bruce provide only nursing, as the home and community support agencies meet other needs, most others, such as Oxford and Chatham-Kent, provide additional services like adult day programs and volunteer transportation. Two branches continue to sponsor the home care program—that's Sarnia-Lambton and Windsor-Essex—and three provide placement coordination.

Other services include foot clinics, respite care to developmental handicapped children and adults, information services and palliative care. By our holistic approach, encompassing health promotion and disease prevention, our investment in the health and wellbeing of people is for the long term, enabling individuals, families and communities to maximize their full health potential in the comforts of their home and community.

1100

VON recognizes the need for reform and is actively involved in the collaborative planning required to imple-

ment an enhanced community health and support system that will be able to provide a quality continuum of care within the limited resources available.

Our brief is going to address four areas and they are outlined. I would like to talk about need assessment versus choice, local uniqueness versus standardization, an ideal concept versus reality, and volunteerism. I recognize that these are themes that you've been hearing.

Firstly, need assessment versus choice. A standardized approach to client assessment shall ensure better consistency in the determination of need. It is clear that the collective absolute need of individuals served in the long-term care system outweighs the ability of the system. Hence, we must have a clear way of determining relative need within resource limitations.

The management of waiting lists, as was outlined in the legislation in part VII, section 21, must be more than a queue for service. There must be an element of triage to ensure those most in need receive the necessary support services to reduce crisis situations. Within available resources, consumers requiring services to promote health and wellbeing should have a choice of needed services delivered in preferred locations by preferred providers. Subjecting individuals to a forced prescription of care is neither helpful nor cost-effective.

Communities may have to decide and limit local choices available to those affordable. For example, a community may not have a critical number of individuals to provide a specialized adult day program to persons affected with Alzheimer disease or physical disabilities and must decide whether to transport the people to another program to receive the specialized care or to provide an all-encompassing program. This presently occurs in the south rural area of Oxford county.

Individuals in need of only one service, such as Meals on Wheels or home support, should have access to the service without being subjected to a complete assessment process. Individuals who know they need respite care or Meals on Wheels should be able to access this service directly. Should they not be eligible, they should have the option of purchasing the service without affecting the funding envelope. The reform needs to support a system of self-reporting and self-application for services, diverting professionals to more complex cases requiring clinical skills. We know many individuals could complete much of the information needed at the time of assessment, given a user-friendly tool. We question the direction of the legislation regarding compulsory needs assessment by MSA staff for eligibility for all services.

We recognize and value the role of physicians in meeting medical needs and their contribution to the health and support team within the continuum of care. We believe persons receiving services are entitled to the rights that are outlined in the legislation, in the bill of rights for persons receiving services. Our VON philosophy respects the rights of individuals and believes that individuals have primary responsibilities for their own health. Direct funding to consumers or care givers to purchase services directly or from the MSA would promote responsiveness to consumers by MSAs.

We believe a reformed long-term care system must

support equity and have balance between need and want, local community uniqueness and creativity and provincial standardization and equity, as well as balance the concept of an ideal theoretical model with the given realities of the day.

I will next address local uniqueness versus standardization. The VON recognizes the need to build on local uniqueness and yet provide enough standardization, as referred to in part I, section 2 of the legislation, to provide efficient and effective service as well as equity between communities. We do not yet know the outcome of the present capping of home care budgets and need to continually assess the impact of these changes while in transition. To accommodate for local variances, the new multiservice model must be flexible enough to meet the needs of residents and yet consistent with provincial guidelines to promote quality and ensure equity.

It would appear that it is the intention of the government to create multiservice agencies province-wide that will result in the total amalgamation of the current agencies that provide community-based services. There is an important need for flexibility in the implementation of the MSA and the opportunity for communities to develop models that meet their unique needs. We are recommending that the province accept alternatives to amalgamation, as arrived at by communities, that may include a federation of agencies or other models to achieve a multiservice system and to achieve the goals of long-term care reform.

From the consumer's perspective, we accept there is an urgent need to integrate at the front-line level of service delivery and to simplify access to needed services. There is no doubt that service providers can work as a team, sharing common assessments, charts, care plans and values. Through these efforts, duplication can be eliminated and better coordination can be achieved. In many of the VON branches, interagency committees have been established already to immediately tackle these issues.

Additionally, community agency sponsorship avoids having another level of government or agency board or commission of government, such as health units, sponsoring the MSA when it may well have other priorities and therefore may not give the MSA the focus it deserves and requires. The selection of individuals who make up the board which governs the MSA should be locally determined to best meet needs for the local community. It needs to reflect ethnic and cultural diversity, for example, in Kent county, where there may need to be representation from, among others, the native and French communities. We are recommending that the standing committee on social development support our request for flexibility by amending part VI, subsection 15(2) to remove the four-year limit on transition to a fully amalgamated MSA.

Our third point is ideal concept versus reality. The fully integrated multiservice agency is an ideal concept to create a one-stop shop for those in need of long-term care services. Given different local environments, we believe the governance and service delivery models must vary to best meet the needs of communities and service utilization patterns. Many communities such as Grey-Bruce do not have a significant number of provider agencies—

seven including home care—and the access, coordination and integration of services could be achieved within a cooperative endeavour without dismantling the present system.

The Windsor-Essex branch recently formed a partnership with the local Red Cross agency and home care program in the interest of system improvements, such as a shared client record. In Grey-Bruce, the district health council has put aside the MSA governance issues to deal with practical improvements to the system, such as one assessment tool. We believe the amalgamated MSA has yet to be tested.

During transition, it is important that the current solid foundation of community supports not be destroyed in achieving redirection goals. We are concerned about creating a bureaucracy which is inflexible and diverts dollars from individuals in need of care to an unnecessarily complex and costly system. We believe a partnership MSA with a federated board is more likely to experience a synergy of federated volunteers. Shared recruitment would improve the choices volunteers have as well as shared training, particularly in specialty areas. These are achievable without total integration.

Critical to the success of a reformed system is the development of databases which eliminate the costly present duplication of information and assessment. This has been one of the most significant handicaps of the present system. The joint VON-Ministry of Health direct billing project is an example of how collaborative endeavours result in efficient and effective systems. The investments the government have already made in this area have been significant, and experience gained needs to direct future improvements required.

An automated management information system using data standards province-wide is necessary to allow comparability on quality management indicators. Sharing information between MSAs and publication of comparative data encourage responsiveness, cost-effectiveness, collaborative problem-solving and innovation. Experience within VON has proven this without taking away any local authority.

1110

The realities of a fully integrated MSA become extremely complicated within the human resources area. VON, along with other long-term care community health and support service providers, has requested from the ministry protection for non-union staff similar to the protection afforded under successor rights in the Labour Relations Act for unionized staff. We are requesting that the committee make a strong recommendation on behalf of non-unionized employees for equal protection with unionized employees as this new system is created.

Critical to the success of the new system is the transfer of the valuable skills and experience of all community agencies that for many years have made a significant contribution to our communities. In the interests of those receiving care, we hope current staff have equal access to jobs in any new MSA.

Severance costs for non-profit long-term care community agencies could be significant. In contrast to for-

profits, all moneys of not-for-profits are returned to service in the community and thus few organizations have equity to pay severance.

My final point is in volunteering. I am not a paid staff member of the seven VON branches. I am a volunteer. I've been a member of the board of directors of the Middlesex-Elgin branch for seven years and I'm currently in my second year in my term as president of the board. I'm also an elected representative to the provincial governance structure in the VON, which we refer to as the constituent assembly, and I sit on the executive of that body. When people ask me how much of my time these activities take, I tell them that I'm afraid to add it all up. It would be too scary to know.

Why do I volunteer? I am a very busy person. I work full-time in a demanding middle-management job, I have three young children and in my career I don't make business contacts through volunteering, which is often the motivation for many, so it isn't enhancing in any way that aspect of my life. I became involved as a volunteer with VON because I believed in the value of that particular organization. Unlike one of the previous speakers, I do believe that volunteers are quite committed to a particular organization because of the values and the things that organization represents. I felt I could help them to accomplish something worthwhile and that it would make me feel good, and that was why I did it. VON is a charitable organization as well as a not-for-profit and it gives back to the local community.

Across Ontario, there are thousands of volunteers like myself helping such organizations. Because this volunteer involvement is so tightly tied with agency identification, I wonder how successful a multiservice agency will be at recruiting or replacing those hours of volunteer service and commitment.

In summary, the VON is committed to the principles and ultimate goals of the government's long-term care policy. We strongly support the need to further develop a cost-effective quality system that will increase consumer participation in decision-making, simplify access to service, reduce duplication and improve coordination of service. The question is how to get to the redirection goals without destroying the solid foundation in place today.

The VON of Chatham-Kent, Sarnia-Lambton, Oxford, Middlesex-Elgin, Grey-Bruce, Perth-Huron and Windsor-Essex counties request that this act and any regulations to the act be flexible enough to allow for partnership models for MSAs involving a federated board and an integrated service delivery model.

Thank you very much for your time.

The Chair: Thank you very much. Just before turning to questions, I'll just tell members of the committee that the representatives from Belle River are here, so after Mr Winnerger we'll move back to Belle River.

Mr Winnerger: It's indeed a pleasure to hear you present today and also to have met you at my office yesterday. You gave me a bit of an inkling as to what you were going to say today. In connection with two of the many different points you made, I wonder if I could

ask you what value you see in removing the four-year cap on transition to a fully amalgamated MSA. That was one of the requests you made in your presentation. Either of you.

Ms McCallum: By enshrining in the legislation that there is a time frame of four years to a fully amalgamated MSA, you prevent the possibility of partnership or federated models. For many communities the ultimate definition of an amalgamated MSA would not be what would work best for that community, and I think that is some of what you've been hearing.

The legislation should be written in a permissive way so that it does allow for the communities, through the district health councils and the long-term care planning processes, to design the MSAs to suit that community. For many the amalgamated would not work. That's why we're recommending that time frame be taken out. It does allow for either to occur, depending on the community.

Mr Winninger: I see. A second point was your concern about the individuality of the organization, such as the VON, being swallowed up in the MSA. I know yesterday I drew your attention to page 28 of the Partnerships in Long-Term Care guidelines. There was a very useful suggestion, I thought, made there, such that an agency that has a profile, as the VON has had over the last 100 or so years, could promote and identify itself perhaps as, "The VON, a proud member of the London-Middlesex LTC multiservice agency." Would that not respond to your concerns about identity of volunteers with a particular organization yet it's also a part of a larger multiservice agency?

Ms McCallum: I think what you're identifying, David, is somewhat in conflict with what is in the legislation. Some of the early discussion documents did seem to allow for more of a partnership rather than a fully amalgamated integrated model. What the legislation is saying is that within four years there will be a full amalgamation. As Mr Wilson is saying, our staff who work now in the services that are provided to clients who would be under the MSA would no longer be VON staff. That's why we're concerned about the security for their positions. Therefore, the VON as it exists today would have to be quite different. It doesn't mean that we couldn't exist, but we couldn't be part of the MSA as this legislation is drafted.

Mr Winninger: Originally the VON was accorded a little additional time because of all the chapters. I know Kimble has a quick question, if there's time.

The Chair: I'm going to allow a few more because of the fact that we're dealing with seven organizations, but I'll go next to Mr Wilson.

Mr Jim Wilson: I just want to follow up on this point, because it's important that everyone know that what you've said is correct, in spite of all the wishful thinking that the groups that are being swallowed up by the MSA are somehow going to survive and have some distinct identity so that they can continue their individual missions and purposes and objectives and retain their volunteers. It's simply not the way this legislation reads, nor is it the model. Eighty per cent of services have to be delivered by the MSA, and those people become

employees of the MSA.

I want you to know that so far we've had discussions with the government about what happens to all the VON's cars, your capital, your offices. They're telling us they're dealing with that right now. The government had already said that it will cover severance pay for the thousands and thousands of people who work for VON and Red Cross and Catholic Charities, so this isn't mythology. They already have plans in the works to swallow you all up.

I have no idea how you're going to survive, because for people who are eligible for long-term care services in the future the purchasing of services from outside agencies is limited by the 80-20 rule. I don't think there would be enough business for the VON outside of the MSA to keep a critical mass to keep the VON going.

Maybe you want to correct me on some of this, but I just don't want people to have misconceptions about this legislation. This is a monopoly. It flies in the face of what we've learned about monopolies in the last 20 years. It's essentially regional government for health care, which flies in the face of our experience with school boards and large bureaucratic organizations. It's exactly the opposite direction to what many of the government's own discussion papers had.

The problem—and I want to ask you this question—is, where did the idea come from that the MSA would not only be one-stop shopping? All politicians—God knows I've only been elected four years, but I was an assistant for many years and used to write speeches for politicians about these things. It was essentially a 1-800 number or something for a local area, and a fairly simple agency would be set up.

1120

That's what I heard during the public consultations on long-term care, but these people came along and put a nice little twist, that they also have to have a monopoly on delivery of services, which, as I read the government's own papers, was never intended until you get to, like, the salmon-coloured one where suddenly or so it's thrown in. Have you heard an outcry from consumers that, first of all, for some reason VON and Red Cross have got to go, and other service agencies, and that they want the government to have a monopoly on the delivery of services? Because we're told very directly that that's what they heard during their public consultations.

Ms McCallum: It's sort of awkward for me to answer that. What we believe should happen is that the communities, through the district health councils, should plan the structures. In that way they can be responsive to the needs of the community and the clients there, and that is the opportunity where the voices of the consumers should be heard.

We attended many of the previous committee hearings and discussions and what not. We hear things perhaps somewhat differently and yet I don't want to criticize what the government has gone through. What we're really saying is that the legislation needs to be flexible enough for the committees within the communities to design them and not a cookie-cutter kind of approach to

this being what the MSAs have to be. That's one of the reasons why that four-year time frame is a bit too restrictive.

If the district health councils are empowered and given the resources that they need to properly do community planning, then things will be designed in the way that the community and the consumers need. If all clients or consumers have equal opportunity to be heard, to be involved in the committees, and due process for planning occurs, then it should be in the best interests of the community.

If that means that all service provision is underneath one organization and that organization takes our staff and some of our work with us, so be it. We will alter our structures and our service provision and we will continue. I mean, it's been done in other provinces in a smaller way.

It doesn't necessarily mean the demise, and that's not why we're here. We're not here to protect VON. What we're trying to say is: Consider these things. Let the communities do their planning and let everybody be heard and not any one particular vested interest group drive the process.

One of the criticisms of some of the input that has gone into the government has been from the perspective of the seniors, and it's been well and healthy seniors as opposed to ill seniors. It takes a lot more work to get the ill seniors' voice heard than some of the more organized healthy seniors. That's another aspect of the community planning, to establish it in that way.

Mr Jim Wilson: If I can just add, you did mention other provinces. Manitoba is an example but Manitoba has reversed the monopoly aspect of it because they found it wasn't efficient.

Mr Sutherland: Thank you for your presentation. I guess I had a question. Instead of an MSA, you propose a federated board type of model. On page 7 you talk about your concern about the MSAs, about the bureaucracy which may be inflexible and divert dollars from individuals in need of care to an unnecessarily complex and costly system.

We've heard a lot about the so-called large and, as some have called it, monolithic bureaucracy that an MSA is going to be. You talk about the costs of administration. What if I put forward the argument that the sum of the administrative costs of all of the individual agencies now may be more than what the administrative costs of an MSA are going to be. If that is the case, in the federated board model that you're putting forward where is the administrative streamlining? I didn't quite see that in your presentation, as to where administrative streamlining comes in. You say the boards all work together, but the sense I get is that they're all retaining their separate administrative structures. I don't see where the savings are or the administrative streamlining come from in a federated board model.

Ms McCallum: It wouldn't necessarily. Retaining the individual identities of the organizations and the board structure, the governance structure of individual organizations, the values etc and then a federated board that

could have representatives from the different groups, does not necessarily mean that you wouldn't collaborate on an administrative structure. There's no reference to that in there. The governance structures—those are all volunteers in the organizations that I'm talking about. The board for the VON are all volunteers from the community.

Mr Sutherland: You said you could collaborate on the administrative structure. I guess, then, if you say that is an important part of administrative streamlining and you collaborate on the administrative structure, then what is the difference between a federated board and an MSA if you're collaborating on the administrative structure?

Ms McCallum: The identity.

Mrs Haslam: Actually, the boards are elected in an MSA.

Ms McCallum: Yes, that's one of the pieces of the legislation. They are elected or more formally appointed, as opposed to volunteer.

Choice: When you look at what's in the best interests of the community, if there is no choice for the client or the consumer—and someone else identified that this morning—it is a definite concern that we take that choice away.

Mrs Yvonne O'Neill (Ottawa-Rideau): Perhaps you were here for the Lambton women's institute presentation. They talked quite a bit about the district health council and what they expected of it. I found your intervention regarding the Grey-Bruce District Health Council rather interesting. I don't know exactly how this has happened. It's the first one I've heard about that seems to have decided to put MSA governance and its accompanying concerns on the back burner and go another route. I'd like you to say a little more about that, whether everyone on the council agreed to that or how that decision was made. Are you working towards fitting into Bill 173 eventually? At the moment, you seem to be working on other things. At least that's what the brief says.

Ms Kathryn Bamford: Kathy Goetz-Perry, who is the director from the Grey-Bruce branch, is here. She could answer that for you, if you like, if it's possible.

Mrs Catherine Goetz-Perry: My apologies for being late; I wasn't aware we'd been moved forward. In relation to your question, the actions are endorsed by the long-term care advisory committee of the district health council. The intent is to address the service delivery issues of access, integration and coordination first in relation to consumer and stakeholder issues and resolve those problems, those seen as the priority problems, and then address the issues of structure and governance.

Our region happens to be unique in that we only have about seven service providers actually involved in direct home and community support services. In 1992 the Home and Community Support Services Agency was formed as a pilot in Grey and Bruce counties, as you may be aware, to undertake the community and home support segment of services in Grey and Bruce counties. That agency is fairly new in its mandate and is still attempting to address all areas of its mandate.

That leaves a total of four other agencies, including

Grey-Bruce Home Care, that are directly in health services. Three of those four are regional in nature. They service all of the Grey and Bruce counties and do satellite service delivery of some type or another. It seemed a natural outcrop of our layout of services in the community to proceed with resolving the issues that came forward as priorities in our community from focus groups held with consumers and stakeholders, those being access and coordination between present providers, and get those issues out of the way first, before we undertake the structure and governance.

1130

Mrs O'Neill: Are you dealing then with some of the frail elderly who have just been mentioned, or are you dealing with just the well consumer?

Mrs Goetz-Perry: We are struggling, as are other regions, in getting the mandate and voice of the frail elderly heard, but in fact the district health council has undertaken direct data information by going out to stakeholders and visiting with clients in conjunction with stakeholders to access those frail elderly consumers.

Mrs O'Neill: I certainly endorse your approach. My final question, do you have a time line?

Mrs Goetz-Perry: In that this project has just been undertaken and that there are workshops set for October 6 and 7, I can address your question at that point.

The Chair: Thank you all again for coming together on a joint presentation. We appreciate what you've done today.

I have two questions that members just want to put, and I go first to Mr Winninger and then to Mr Wilson.

Mr Winninger: I have a question of clarification, and without taking too much time away from the presenters, I wonder if the parliamentary assistant or the ministry officials could indicate what opportunity, if any, there is for organizations such as the VON to maintain their identity once the MSA becomes fully functional.

Mr Paul Wessenger (Simcoe Centre): I'll ask legal counsel.

The Chair: Again, just because of time, if we could be fairly brief.

Ms Gail Czukar: There's nothing in the legislation, of course, that requires VON or any other organization to give up its corporate structure, and so VON and Red Cross and all those organizations can continue as corporations and as non-profit charitable corporations. Whatever activities they carry on outside the publicly funded services that would come within the jurisdiction of the MSA could continue. So they would be able to retain their identity and their structure in the community. Beyond that, it gets a bit complicated.

Mr Jim Wilson: I guess the problem with that, though, is the vast majority of services that a number of these groups are providing are indeed publicly funded. All of those services are being expropriated and put into the MSA.

I want to ask the government, once again, whether it has any studies whatsoever to tell us what the costs of the current administrative structures of the various agencies

are now, because Mr Sutherland said it once again in his remarks that the premise of this legislation is that amalgamation will save money. That flies in the face of any amalgamations that we've ever done in this province.

I just went through one in the county of Simcoe where after they amalgamated many of our municipalities, we actually have the first debt in 150 years of over \$1 million, because bigger is not better. So I think we are entitled as legislators to know what the benchmark is so that we can measure in the future, through the transition process of MSAs, whether or not there are cost savings when administrative structures are amalgamated.

Has the government to date come up with those figures?

Mr Wessenger: Certainly, if we look at the hospital sector, I'm sure we can provide information that shows, as a result of the combination of administrations, there have been administrative savings in the hospital sector. In fact, we heard in Sault Ste Marie about a saving of \$2 million as a result of two hospitals coming together.

Certainly if we look across the spectrum of other areas, we see the efficiencies achieved by streamlining administration. That certainly is a trend we have to continue to do in all sectors, including the sector of the long-term care area.

It's interesting to have heard, for instance, the last presenter, who seemed to have some indication that a federated model, to be efficient, would have to have some common management, some common administration—in other words, to have achieved those efficiencies—and who expressed really I think the concern that they really wanted to retain an identity for them more so at the governance level rather than the administrative level. I think that certainly the evidence we've heard, as far as savings, there is a lot of information.

I don't think there are any particular studies in the long-term care area because we haven't had an MSA model up in operation yet, but certainly with respect to the district health council planning process, they are looking at projected costs with respect to the MSA models they are developing and that's part of the whole planning process and that will be submitted to the ministry together with a recommendation of any new model to show the cost savings that may be effected.

Mr Jim Wilson: That's complete bunk and comparing apples to oranges. We have no administrative structures in hospitals in this province that are 100% volunteer as we do in the community-based sector. In many of these agencies—for example, Meals on Wheels throughout the province in many cases has nobody paid to administer or run those programs; strictly volunteers. In a number of other agencies and in fact the evidence before this committee from almost all of the deputations has been that there will be no cost savings. To compare it to the hospital system, you know, Mr Wessenger, as parliamentary assistant, that many of those savings came outside of the administrative envelope when hospitals have been merged. It's still, I think, incumbent upon you, if you're going to continue to make the statements in this committee that savings will be achieved—you've got to be able to prove that in fact, prior to the implementation.

The Chair: Final comment from the parliamentary assistant; then we'll have to move on.

Mr Wessinger: I'd just like to point out that certainly with respect to the hospitals, the savings that were achieved, they were proven as a result of the structure; there were no pilot projects in a sense. When you do this restructuring, you have to base it on your best information and your premises. Certainly the district health councils—I'm sure they're looking at these matters—can see the savings when you cut down the number of administrators. Your payroll department cutbacks and in the sense your number of chief executive officers is certainly going to make a savings in the administrative area. I can't anticipate how by having less people involved in administration you're going to not have savings.

Mr Jim Wilson: If I may, Mr Chair, the point has been made—

The Chair: I think we have to move on.

Mr Jim Wilson: But in this governance structure, though, which is very often volunteer-based, what about the loss of the volunteers?

Mr Wessinger: Anyway, the county—

The Chair: Order, please. I appreciate the points that are being made. I think the question is on the table.

Interjection.

The Chair: I realize that, Mr Wilson, and I think that's where it is and we have to move on at this point.

BELLE RIVER AND DISTRICT COMMUNITY COUNCIL

The Chair: With us now is the representative from the Belle River and District Community Council. We're glad that you were able to get here and that we can hear your presentation.

Ms Janet St Pierre: Thank you very much. My name is Janet St Pierre. I'm the executive director of Belle River and District Community Council. I will give a brief description of our organization just to give you a clearer understanding of who we are.

Belle River, for those of you who do not know, is located in Essex county just outside of Windsor. It's a small rural community. The Belle River and District Community Council is a non-profit charitable organization concerned with the needs of the residents of the North Shore area of Essex county.

This agency, established in 1985, was organized to plan and organize programs that would meet the long-standing unmet needs of this community. With ever-changing times and an aging population, it was apparent that services needed to be accessed locally. Currently, at one location the residents of the North Shore area can access an information and referral office providing much-needed information to persons of all ages in both French and English. A transportation program, Meals on Wheels, a foot care clinic and a friendly visiting program for seniors and disabled are currently funded by the long-term care office home support programs.

As well, agencies whose main offices are located in other larger cities have placed counsellors on a weekly

basis at our location in order to serve the residents in a better manner. These include the Sexual Assault Crisis Centre, Hiatus House, Essex County Social and Family Services, Essex County Crisis Intervention Program, Housing Information Services, and Windsor-Essex Bilingual Legal Services. Access to fax service and telephone is made readily available to VON visiting nurses and public health nurses.

My area of concern speaks to part VI of the proposed Bill 173, on the establishment and designation of a multiservice agency for specified geographic areas. While we realize that changes are about to occur regarding the provision of community support services with the passing of long-term care reform, we need to be assured that linkages within the MSA be clearly defined and that the services that exist in rural areas continue in the same efficient manner that is currently being provided.

Windsor-Essex county is a geographic area encompassing city and county residents with similar yet very different needs. The seniors living in these rural areas depend largely on the friendliness and personal assistance provided to them by their local agency.

I heard people speaking earlier with regard to the importance of volunteers, and volunteers and community support play an important factor in the delivery of these services from small agencies such as ours. I realize that this has been addressed in Bill 173, but again, my concern is that this be a part that's looked at very carefully in the continuation of these services for small rural areas, as our needs are very different than those in the cities.

That is the extent. It's very short, but that is the main concern.

The Chair: Thank you, Ms St Pierre. Just for the record, I note that you've included a copy of the programs and services that are available at the local community information centre, and would note too, just before passing on to questions, that we have had a couple of presenters today who have also put emphasis on the particular needs of rural communities. So while your remarks may have been short, they fit very much in with other things we've heard today.

Mrs O'Neill: If we're putting the program in, I think you can certainly be very proud of the services you've been able to achieve and offer. I guess I have to ask you just where you are in the long-term care planning process. Are you or anyone from your organization involved in the long-term care committee of the district health council? I presume your district health council does include the cities.

Ms St Pierre: Yes, it does. The district health council has been deliberating for a couple of years now in Windsor and Essex county. I myself have not been directly involved on standing committees, although I have been involved in some meetings of other committees. Information hasn't been made available to myself through the committees to make sure that we sort of understand what's happening in our area.

Mrs O'Neill: I guess my question then is, do they understand what's happening in your area?

Ms St Pierre: I don't know. That's one of the concerns, that we don't really know if the cities do really understand the needs of the rural areas within, encompassing, a large multiservice agency that takes care of city and rural people all in one group.

Mrs O'Neill: And you really don't have a defined membership on the district health council then? Is that what you're saying, that the rural—

Ms St Pierre: We have four social planning councils serving the Essex county area, and we do have representation from these social planning councils on the MSA committees. There are voices there, yes.

Mrs O'Neill: Do you get the feeling when you read Bill 173 that it is quite, what should I say, a metro model or a large-city model?

Ms St Pierre: Yes, I do, and that is my concern specifically, that it looks like a large metro model and perhaps these small areas will be forgotten.

Mrs O'Neill: Is it the list of mandatory services that's frightening, or is it the governance structure, or what do you feel could be done to Bill 173 to make sure that rural areas and that the language of "rural areas" are included? Can you not even, if you can't do it today, perhaps follow up to tell us just what parts of the bill and the wording that would help? Because let's face it: There are more rural areas in Ontario than there are urban areas, even though there are concentrations of population.

Ms St Pierre: Well, perhaps there could be wording clearly identifying the needs of the people in the rural areas, or that the rural areas would be looked at and considered within these mandates, within the establishment of the MSAs.

Mrs O'Neill: Perhaps with certain exemptions that may be—

Ms St Pierre: Right.

Mrs O'Neill: Thank you very much for your presentation.

The Chair: Thank you very much for coming from Belle River to the committee this morning.

Members of the committee, I think it's time that we dealt either with our acute short-care needs or our long-care needs and have a break, it having been some three hours since we started, and we do have a very long afternoon.

I have some directions for committee members for lunch, and that is that when you exit this room and you go out and turn to your right, go down the hall to salon A, through the glass doors and then turn right again, and I would assume that either Mr Winninger or Ms Cunningham would be able to find us if we got lost. With those—

Interjections.

The Chair: Order. You see, we're getting frivolous. We need that break. Lunch will be served at 12 sharp, so you have a few minutes to get some fresh air. But I think probably we all need a bit of fresh air, and then we begin again at 1:30 sharp with Cheshire Homes, and just to remind members that we will be going to approximately 6, so I think if people could just kind of revitalize the

batteries, that would do us all good.

Mrs O'Neill: Mr Chair, is it possible to have some air in this room? I mean, really, I'm sure that the people aren't coming prepared, with the heat outside today, to sit in this room.

The Chair: We'll look after the heating during the break. With that, the committee stands adjourned until 1:30 this afternoon.

The committee recessed from 1144 to 1332.

CHESHIRE HOMES OF LONDON INC

The Chair: Our first witnesses this afternoon are representatives from the Cheshire Homes of London. Welcome to the committee.

Ms Mary-Anne Elie: Good afternoon. I'm Mary-Anne Elie. I'm a consumer and a member of the board of directors. With me is Judi Fisher, who is the executive director of Cheshire Homes of London Inc, and Grant Inglis, who is the board president.

The board of directors of Cheshire Homes of London Inc appreciates the opportunity to respond to Bill 173. Our response will focus on comments regarding attendant services and the impact of Bill 173 on those services and on consumer rights and participation.

Cheshire Homes of London Inc is a not-for-profit corporation which was incorporated in 1976 under the Corporations Act with the mandate to assist people with physical disabilities to live independently in the community by providing attendant services and accessible, affordable housing in a manner which enables individual responsibility, participation and integration into community life.

Cheshire Homes currently provides services to 50 people with physical disabilities in the city of London in supportive housing arrangements and to approximately 160 people in the counties of Middlesex, Oxford, Perth, Huron and Elgin through the outreach attendant services program. In addition, we provide 24-hour backup service in the city of London and a respite service in the five-county area. We also have a small respite program for children and work in partnership with the Easter Seal Society to provide respite for children at Woodeden Camp outside of London. There are currently 122 people waiting for attendant services in the five-county area.

The attendant services provided through Cheshire Homes of London are funded 100% by the long-term care division of the Ministry of Health. Housing arrangements are funded by either Canada Mortgage and Housing Corp or by the provincial Ministry of Housing. All housing has a rent-geared-to-income component.

Bill 173, part II, interpretation, page 6, sections 3, 4 and 5, list of services: We feel it is critical that the list of services provided in this legislation is comprehensive and that the description of the services is clear. It appears that some services are offered in more than one category, for example, meal services and preparing meals. Currently, these are services provided under attendant services. Will consumers now have to access meal preparation elsewhere and will these services then be subject to a fee for service? These are very important questions for people who cannot survive without these essential services.

Attendant services: There is no mention of attendant services in the legislation nor is there any guarantee in the legislation that attendant services will be offered other than in the multiservice agencies. Consumers in Ontario who use attendant services have fought hard to have the distinction of attendant services from other personal support services recognized. This distinction has been recognized in the new training program for workers which has two categories—personal support worker and personal attendant—and in the work that was done with the Regulated Health Professions Act. There have also been guarantees made to people with physical disabilities in Ontario that they will have a choice of where to receive attendant services.

The compendium to the Long-Term Care Act distributed by the Minister of Health on June 6, 1994, states on page 19:

“Distinct personal support-attendant care services:

“In keeping with commitments made to consumers with physical disabilities, some communities may choose to retain...attendant care programs, with access managed and services arranged by the particular service provider. Communities will determine how their attendant care services are to be organized through the local community planning process. Every MSA nevertheless will provide personal support/attendant care type services for consumers who wish to access these services through the MSA.”

Consumers feel that if the distinction is not stated in the legislation it will ultimately be lost.

Our recommendation: We recommend that the list of mandatory services be well-defined in the legislation. We further recommend that the attendant services be specifically referred to in the legislation and that reference be made to the choice of having attendant services accessed outside of the MSA if that is the wish of consumers in a specific community.

Part III, bill of rights, page 7: We are very pleased to see this very important protection for people who use community-based services included in this legislation. We did not, however, see any specific reference in the legislation that said an approved agency must comply with the bill of rights.

Our recommendation: that part V, page 10, subsection 7(1) be amended to include compliance with the bill of rights.

Part IV, multiservice agencies, subsection 11(2), board composition, page 11: Our concern with this section of the legislation is that there is no specific mention of consumer participation on the boards of directors of the multiservice agencies. We feel it is imperative that people who use the services should be represented on the board of directors which governs the services.

1340

Our recommendation: that Part VI, subsection 11(2) be amended to include people who use the services through the multiservice agencies.

Part VII, rules governing approved agencies, waiting lists, page 16, subsection 20(2): We feel that this section of the legislation which refers to waiting lists needs to be

expanded. There are currently 122 people waiting for attendant services with Cheshire London, over 50 people in the city of London alone waiting for the outreach program. Some of these people have been waiting since 1987. Many people who are waiting for attendant services are using services that are more costly; for example, they are institutionalized or they are using professional services such as nursing.

These services are not only more costly but totally inappropriate and people who want to get on with their lives are forced to play the waiting game. There is no systematic mechanism for monitoring these waiting lists.

Our recommendation: that subsection 20(2) be amended to include a comment about a review and the monitoring process.

Quality management, page 17, section 24: We are pleased to see that the assurance of a quality management system has been included in this legislation, but feel that this section has left too much for the regulations. We question whether process is a more appropriate term than system. Process by definition is ongoing. We feel that the legislation should be more specific with regard to the criteria to be met with quality management.

We also feel the legislation should state that consumers who use the services must be involved in this process and that the information should be made available to the consumers and to the public.

Our recommendation: that section 24, quality management, be expanded to include some criteria for evaluation and reference to the inclusion of consumers in the quality management process and reference to the information being made available to the public.

In summary, the board of directors of Cheshire London is confident that Bill 173 will enhance community-based services and will strengthen protection of rights for people with physical disabilities in Ontario. We hope you will consider our comments as constructive criticism only and we wish you luck as you work towards third reading of this legislation.

The Chair: Thank you. I think all committees appreciate your last point as we proceed to deal with the legislation. We'll go to questions.

Mrs Cunningham: Thank you very much. This is one of the agencies I think, Mr Chairman, that we're very proud of in the city of London for the work that they do. They've been very, very vocal, at least as long as I've been involved, in letting us know what we do well and what we should do a lot better.

I think the waiting lists speak for themselves when we're talking about health dollars: the kind of money that we spend on health care; the fact that we now know this number is 1987 and, until two months ago, I think we could probably have said 1984, in that one of the people waited a decade to get out of an institution, to be in their own place with their friends and family. So we have a lot to be accountable for.

Thank you very much for being so specific with regard to your recommendations. I wanted you to know that with regard to the mandatory services and with regard to attendant services, we have amendments that we will be

putting forward to most of the issues, I think, that came forward today. They're written and we're ready to go. We've certainly heard some of the things that you've stated across the province for at least the last couple of weeks and longer and so we've acted on them.

I wanted to ask you how helpful you think this act will be to some of the challenges that you are facing within your own agency. Where will it be the most helpful, if at all?

Ms Judi Fisher: That's a good question, Dianne.

Mrs Cunningham: We spend a lot of money doing this, you know, rewriting stuff and paying lawyers and all the rest and I often wonder why, so I'm just asking you.

Mr Jim Wilson: We didn't; the government did.

Ms Fisher: Do you want me to answer?

Mrs Cunningham: What's helpful and what isn't?

Ms Fisher: Yes, I think it solidifies the community-based services and gives sanction to much of the work we've been doing. Certainly, there's sanction in the legislation with public hospitals and that sort of thing, where our services in the past have really been a very small reference in the MCSS act and so I think it gives more distinction. In terms of the bill of rights for consumers and the appeal process, it certainly gives consumers a lot to act on that is legislation, so therefore is law. No, I think it's a very, very important piece of legislation for us.

Mrs Cunningham: Could I ask you with regard to the expectations, because when you list the services that are being available, and I know one of your recommendations is to add to that list or to make it more clear—by raising these expectations, I'm assuming you're thinking that we're going to save the money Mr Wessenger talked about today, so we can provide services and not have waiting lists. Do you think that's one of the expectations of the public in this regard?

Ms Fisher: That will save money?

Mrs Cunningham: The waiting lists have been one of the great concerns that we've all heard about. As people come forward, we have to ask ourselves how can we be spending this kind of money per day in an institution, when it's so much less expensive to have someone in their own home?

Ms Fisher: I think probably there are a lot of people who have answered those questions long before I ever came on the scene. Robert Sutherland probably gave one of the best answers when he said the only way we're going to actually save money is if we close the beds and transfer the dollars. I certainly commend this particular government for doing that. The only way we are going to save the money for the people who are on waiting lists in institutions is probably that we somehow close some of the beds and move the dollars. I certainly feel the political will is there to do that.

Mrs Cunningham: Is the waiting list for beds longer now, in the last two or three years, in your agency?

Ms Fisher: We've consistently had long waiting lists and it fluctuates. I've been with Cheshire London since 1981 and when I first came I think maybe the waiting list

may have been 50 and then there've been periods where it's maybe been a couple of hundred and we've been fortunate to get some expansion dollars. There are probably as many people waiting for the services as currently receive the service in almost every area of the province, I think.

Mrs Cunningham: And just the last question, Mr Chairman: With regard to section 23, quality management, wouldn't one of the criteria for evaluation be—at least with your agency—waiting lists?

Ms Fisher: Yes.

Mrs Cunningham: If we pass this, if this goes into effect, wouldn't it be a fair question a year from now? I've been around a long time and waiting lists are growing, in spite of all of the legislation. So if I don't sound particularly positive, I think it's because if something isn't working, fix it; don't write more books. I'm just saying, would that be a fair criterion: You should have less waiting lists for homes and for care givers?

1350

Ms Elie: Absolutely. I can only speak to this from a personal point of view. Without a place like Cheshire Home and the services they can provide—I'm not sick. However, I'm not going to get better. But I don't need a hospital bed. Having a hospital bed and having nurses and doctors around me all the time isn't going to make me get better. I just need some physical assistance to be able to run my everyday life: to get up and go to bed and shower and all those kinds of things. Without places like Cheshire Home that can offer services like that, personal support services, I am looking at spending an awful lot of the rest of my life in a hospital, and there are an awful lot of other people facing the same thing. So we really need things like this, personal support, attendant services, things like that.

The Chair: Thank you very much. I would note, long before I got into this business I remember being at the opening of the first Cheshire Home here in London, and I'll pay tribute to my cousin, Nancy Skinner, whom I'm sure you know, both as a consumer of services as well as somebody who's been very active in working on these issues. So I've felt that I've lived with Cheshire Homes and all that you've done. So, as always, it's a pleasure to have you before the committee and to commend you for the tremendous work that you do, and we thank you for your presentation today.

PARTICIPATION HOUSE SUPPORT SERVICES OF LONDON AND AREA

The Chair: If I could then ask for our next presenter, Participation House Support Services from London and area, if they would be good enough to come forward. We welcome you all to the committee, and once you're settled, please introduce yourselves and go ahead with your presentation.

Ms Elizabeth Leighton: Thank you very much for inviting us here today. My name is Elizabeth Leighton. I'm president of the board of directors of Participation House Support Services of London and area. On my immediate right is our executive director, Brian Dunne; on my left, Carmell Tait, who is the director of support

services for our agency. We've presented to you our paper, and you can see by the question that is the title of the paper our concern, perhaps, in a nutshell. Additionally, we have in the first numbers of pages an executive summary, and we'll leave that with you to read at your leisure, as it simply summarizes the paper.

To introduce ourselves to you as well, we've presented you with a booklet that we have called Participating, Involved, Included and In Charge: Individually Designed Supports, which indicates our philosophy as Participation House and what we hope to do within our community.

We are a community-based and non-profit service agency. We were started in 1980 by parents of adult children who had physical disabilities and often some other disability as well, in fact were started with many bingos and continued in that vein until we were funded as an agency by the Ministry of Community and Social Services in 1988.

These parents and their adult children created this service because the attendant services and other existing community services could not and were not designed to meet their needs. The people required additional support and guidance that was not available to them in the community, and certainly "in the community" is stressed. That is where those people wanted to live. However, they needed more than mere visitation or any kind of on-call services, and today our agency supports these people, who have such disabilities as very severe cerebral palsy, multiple sclerosis, other physical disabilities and often a combination of disabilities. We currently support 32 people under the long-term care ministry. Additionally, we have nine individuals under the Ministry of Community and Social Services. These people are supported in homes and have 24-hour-a-day support, which is absolutely necessary for them to remain in the community, where they want to be.

Our guidelines and our legislative basis for service and funding originally came under two acts, and you'll see that noted in our paper, the Homes for Retarded Persons Act and the Developmental Services Act. However, in 1992 the existing programs were moved to the long-term care division, and in fact currently we are still unclear as to what legislation we operate under. Bill 173 doesn't seem to do anything to help us set the matter straight, and in fact that is because our perception of this bill is that persons with these great needs seem to have been left out of the bill.

The continuing lack of clarity, the fact that after two years no one within the Ministry of Health appears to be able to tell us exactly where we as an agency and a support service fit in, nor have officials taken time to make that determination, explains why the people we support and their families and those on our long waiting list have felt excluded from long-term care reform. Last night you heard from Deborah Jazey, on the Waiting With Concern Committee. She is the chair of that committee, and they represent that kind of feeling of exclusion. The vulnerability for persons with great disabilities seems to have increased. Their needs have been ignored.

It appears to us that there has of course been a philosophy of deinstitutionalization and community living.

However, it appears to be misunderstood, and particularly with regard to the concept that this is for all persons no matter what and how severe their disability. It is inferred that those with high care needs have no guarantees, nor the right to live in the community, as their "dollar could be used to support so many others," and we've put that in quotes as that is a quote that we've heard many times. The concept of basic entitlements for all and equity in having basic needs met, in our practical experience with long-term care, has been replaced by concepts of, again I quote, "bang for the buck." Bill 173 and the long-term care reform lacks a clear commitment to all individuals with disabilities in the community. It fails to guarantee concrete services and functional support.

For our paper, we wanted to look at how this bill had things to offer to the people that we support. We wanted to look at what perhaps has been simply forgotten in the bill and what our overall impression of this bill is and the impact on the community.

Therefore, we've looked at the seven stated goals of the bill and we're going to give our opinion as to whether or not we feel those goals can be achieved for the individuals that we support, those individuals with severe and multiple disabilities who require 24-hour-a-day care. These are the people that we deal with.

Goals 1 and 2 you'll see at the top of page 7, and all of these goals quite frankly seem to be goals we would like to see have a final achievement, certainly as far as the persons that we are dealing with. However, the goal to provide a wide range of community alternatives to institutional care and to improve community services falls short with regard to our people, because we see the bill as being silent regarding the fate of people who are very difficult to serve. It does not guarantee that all people will have their basic needs met within the community regardless of their level of disability. People that we support were last in line to receive service before, and now we wonder whether or not they'll even get into the line, under this bill. More and more services are being moved to the community. However, there appear to be fewer and fewer guarantees being made.

1400

When you look at community service, you realize that it doesn't seem to ever have had the power or prestige that entitlement and guarantees have had. Greater numbers of people are being pushed into an uncertain position; those most vulnerable are most likely to lose. Our reading of this bill is that it clearly lacks the philosophical commitment and teeth to ensure people who have high levels of disabilities will get their needs met and experience quality of life, again underlined, in the community.

The bill also continues the waiting list placebo. I was listening to Dianne Cunningham's comments. It appears that you're all aware of the waiting list problem. This problem has gone on in the community for years, and our reading of this bill is that this issue is not addressed. Service providers, families and consumers attempt to plan for their future. That planning is impossible, given that only ministry funding decides on movement on a waiting list. If the bill, as we read it, doesn't guarantee service or

movement, those people are going to continue waiting and be unable to plan for their future.

The artificial limit that only 20% of services can be purchased from other services by MSAs ignores the needs that individuals may have. It's an artificially created number. It doesn't seem to have a rationale in consumer need.

Finally, the bill has ignored the most important questions, again leaving people that we serve in limbo, those questions being: What are the basic needs that will be provided for in the community? Additionally, is there a cutoff point or a maximum that will appear in the regulations after this bill has been passed? Are those we support allowed in the line, or is it possible that they will lose their community service?

Those who are in the community and who brought dollars with them from the Ministry of Community and Social Services do not appear to be guaranteed continued support in the community by this bill. You cannot leave entitlements and maximum amounts of service to be determined by officials and bureaucrats within the Ministry of Health. This should be clarified before the final reading of the bill.

The next goal is to recognize the importance of a person's needs and preferences in management and delivery, again an excellent goal. We commend you for looking at consumers' rights within service.

However, we question why the choice of service provider has been limited by the creation of MSAs and a 20% limit for purchase outside the MSA has been chosen. We wonder why the concept of individualized funding was not looked at. If you can change the service, why can't the individual pick the provider?

The cost and quality would come quickly into place if the consumer was able to dictate the expenditure of his or her dollars. This would be less costly and ensure quality far more effectively than the cumbersome review and appeal process and the quality assurance outlined in Bill 173. The bill does not clearly define the objectives, methods, jurisdiction or enforcement procedures of quality assurance.

Goal 4, the creation of these MSAs: We wonder what the intent of this change is. There appears to be nothing in place within the legislation to ensure that the amalgamation of service must be or is directly tied to more dollars going to front-line and direct support to an individual consumer, nor does the bill imply that those services that spend the largest percentage of government dollars on direct care will lead the process. It appears that lost is the intent of saving dollars for consumers' use. The legislation does not appear to ensure that when all is said and done, there must be clear results from the amalgamation. Of course, we're all very much realizing that in this day and age we're looking for improved services for many more individuals, using the taxpayer's dollar, and it is the taxpayer who is questioning more and more how those services are being provided, how that dollar is being used.

Goal 5, improved and consistent accountability regarding equitable access, rules and procedures: Again, back to

the taxpayer, who is saying, "Who's accountable for the use of my tax dollar?"

We feel that this bill has not addressed the question of equitable disbursement of finite dollars to those people with needs and disabilities within the community and how that will occur. This cannot be left to be defined out of the public eye and within the bureaucratic system. This goes to the question of entitlement and guarantees for all.

Moving greater numbers of people—and we've indicated seniors, acute home care, people with AIDS—away from the protection of the Canada Health Act will leave the most vulnerable and least vocal within the community, and those are the people that we support, at the bottom again, pushed farther back in line for community service. How is the bill accountable to these individuals? What guarantees are they given? We do not see how the stated goal of equitable access translates into equitable service provision.

So goal 6, which is again accountability, we feel is not clearly outlined in the bill with regard to the lines of accountability. The diversion to provincially appointed community councils which lack clear local decision-making power and concrete community support is perhaps just an illusion being created to keep the ministry from being held accountable. There seems to be a blur of consultations and an infinite number of committees and subcommittees of the council. You heard from Deborah Jazey last night her committee's feelings of being simply put off from one committee to another committee. It appears that all the efforts of these innumerable committees simply deflect energy that might well have been used to reform and improve the service to the individuals. Is this bill simply distracting the attention away from the people who are in need?

Goal 7, then, the local planning through the district health councils: These are councils, of course, that were already in existence and have now been given an enormous task, and we question whether or not that task will make them simply another confusing layer within the reform process.

Additionally, this is an appointed body, and we wonder if indeed it will represent its community. How will it be accountable to the local community? We have some local planning. However, there does not appear to be a right or power or any kind of local membership. An appointed consumer representative does not necessarily represent or is not necessarily the choice of the consumer. Indeed, practice has shown that a number of persons who belong to long-term care committees under a category that is called "other" are in fact a disproportionately large number of service providers, a category on the committee that is already there.

We are service providers, and we have become totally confused as to how the ministry office, district health council and MSA will interact functionally. We feel that the bill should attempt to clarify that. Our perception of the bill as it reads now is that it's a proposed reform that leaves us still in a state of confusion and chaos and stagnation.

In closing, of course, as I indicated before, the goals are admirable and we underline them. Unfortunately, little

within this legislation seems to be specifically defined to provide us with a sense that the drafters of the legislation have had a clear idea of how to achieve the goals or have a clear commitment to those goals.

1410

What is the real intent of this legislation regarding specifically those people we serve, people with great disabilities? By refusing to define clearly and precisely entitlement, equity of service provision, basic needs guarantees, those people we support and those who wish our support continue to be left vulnerable and in fact with a feeling that they are unsupported within the community. Thank you very much.

The Chair: Thank you for your presentation. I know that the parliamentary assistant wanted to comment on a couple of the points for clarification.

Mr Wessenger: I think I'm going to ask ministry staff to explain how your organization fits under this bill so that it will be clarified.

Mr Geoff Quirt: As you pointed out, the government's responsibility for funding your program did shift from the Ministry of Community and Social Services to the Ministry of Health. There were a number of programs that served people who were labelled as both developmentally handicapped and physically disabled, where there were discussions about whether it was most appropriate for Comsoc to continue to fund those programs along with its other programs for developmentally handicapped people or whether it would be better for your program to be considered among those that serve people with physical disabilities.

You are funded under the Ministry of Health Act. You used to be funded under the Ministry of Community and Social Service Act. Neither act says anything about disabled people or developmentally handicapped people. This will be the first time that there has been a piece of legislation that addresses community services for the people you serve.

It's not our intention to take your money away. We're almost doubling the amount of money that we're spending on supportive housing programs like the one you operate and we hope there'll be a much more flexible and increased approach to attendant care services. But, as you pointed out, we're not going to eliminate the waiting lists. We hope we'll have an impact on reducing them by providing more service than we do now.

Ms Leighton: I'm going to take under advisement what you've said, especially those last few words. Thank you very much, and I hope that we'll see that sooner rather than later.

Mrs Haslam: I want to mention accountability, because accountability is one of the things that I think the consumers really want. They want to have a local board, and when you talk about the district health council not being reflective and appointed boards and things like that, I'd like to point out that the reason we're putting in place elected boards at a multiservice agency is so that consumers can have access to and input into the decisions around what kind of an MSA they're going to have, and the accountability for them is there not only in the bill of

rights but in their input into that MSA board. I would assume that you would be very interested in being part of that process, in putting in place that board for a multiservice agency.

Ms Leighton: We would, of course. I think the point we were trying to make was that with appointed members, specifically of the district health councils—and of course our position is, and I think it's the position of most taxpayers in Ontario, that the dollars that are taxpayer dollars should be used most wisely and should be used to give the consumer as much as possible what the consumer is looking for. Our concern is of course that the consumer does not seem to have been included in these district health council appointments and that perhaps with another method, of the district health council perhaps being elected, the consumer at least would have a vote there.

Mrs Haslam: We have a brand-new district health council. We were the first ones to look at it and the last ones to get it in the province. I see a good input from all of the community into that district health council and I see that council working very closely through subcommittees, through volunteers, through long-term care committees, with many people in the community to put together that planning. If that's not the case in your area, then I think maybe that's something you can address here.

Ms Leighton: I don't think we're really pointing the finger at an area at all. What we're doing here, at least from my perspective, would be to look at this legislation from a taxpayer's point of view and to wonder if in fact the taxpayer generally, not necessarily the consumer himself, can say, "I have had input into this, I have voted for this and if things go wrong I can change this." I think that more and more taxpayers are wanting to do that as they become more and more perhaps critical of how their dollars are being used.

Mrs Haslam: Can I ask for clarification on that one?

The Chair: Quickly, please.

Mrs Haslam: Are you making a difference between taxpayer and the consumer of the service? Are you saying taxpayers should have more input than the consumers? Are you making a distinction between those two?

Ms Leighton: No, not at all.

Mrs Haslam: It sounds like you are.

The Chair: I'm sorry. We have a full afternoon and every now and then I have to play the heavy. We appreciate very much your coming before the committee and for your presentation and wish you the very best in all your good works.

Mrs Haslam: In between, I'd like a clarification also from the ministry. In the previous presentation from Cheshire Homes, I was unclear about what something in their document was and that was on page 3. They said that there was no "specific reference in the legislation that said that an approved agency must comply with the bill of rights." I'd like a clarification on that because I believe that the bill of rights does cover that approved agency. Could I have clarification on that?

Mr Quirt: It's my understanding that the bill of rights applies to service providers in the act, which would

include both approved agencies and multiservice agencies.

CITY OF WINDSOR SOCIAL SERVICES DEPARTMENT

The Chair: Welcome to the committee. When you're ready, please go ahead, and also introduce yourselves for Hansard.

Ms Dana Howe: I'd like to introduce us. On my right is Mrs Peggy Davis. She is our director of special services with the social services department and she's also a member of the long-term care committee of the district health council locally. I'm the commissioner of social services with the city and I'm also on the implementation committee of the hospital reconfiguration in Windsor.

We're very happy to have the opportunity to be here today. We have indeed used almost every opportunity to petition the government on this issue that we feel is very important and lacking in the long-term care legislation and in other legislation. To start off with, we'd like to commend the government for its recent actions, through this bill and other related legislation, in recognizing the unique needs of long-term care consumers.

Bill 120, the Residents' Rights Act, which established retirement homes, hostels, rest homes, lodging homes etc as care homes, should do much to manage the tenancy and housing issues. However, the care component remains to be addressed. Likewise, while Bill 173 establishes the policy framework for community-based long-term care services, the legislation is also silent in respect to the needs of individuals who reside in care homes, which aids to perpetuate existing gaps in service provision.

With the enactment of the long-term care legislation, the opportunity now exists to confirm and ensure appropriate service provisions for the residents of care homes who are among the most vulnerable in our communities. If the vulnerability of these residents is to be recognized and if vulnerable adults in the province are to receive the protection necessary to their enjoyment of the same rights and quality of life as other citizens, further steps must be taken to ensure their safety and wellbeing. The basic fact remains that should a resident of a care home have a concern over the care provided, there is nowhere to turn, there is no one to call, write to, no provincial authority designated to ensure accountability or otherwise.

1420

In August 1992, Windsor city council endorsed a submission to the Commission of Inquiry into Unregulated Residential Accommodation outlining 19 specific recommendations which we have included as an appendix. Among those recommendations, however, we highlight:

(1) That the province should assume responsibility for regulation;

(2) That the province effect regulation through amendment of existing legislation, ie, the Ontario Building Code, the Homes for Special Care Act and the Landlord and Tenant Act;

(3) That the province establish an adult protective services program;

(4) That the care operators be required to enter into individual lease agreements with the residents on an annual basis;

(5) That the province recognize the empowerment of the individual as primary in the development of regulation; and

(6) That the province initiate a pilot program within a community where there exists an effective municipal bylaw regulating care homes.

Further to the release of the commission's report, A Community of Interests, Windsor city council, in September 1992, unanimously endorsed Dr Lightman's 144 recommendations, including the recommendation that Windsor be considered as a site for any comprehensive community care pilot program. This resolution was communicated to the ministers of Citizenship, Community and Social Services, Health and Housing.

In response, the Minister of Community and Social Services advised council of the government's intention to review the recommendations of the commission while establishing an interministerial committee to assess the recommendations. The Ministry of Community and Social Services then engaged Ernst and Young to conduct a domiciliary and emergency hostel review, the final report of which was released in November 1992. Further to this review, a project to reform the GWA, general welfare assistance hostel system, has been announced, in which this municipality has been invited to participate.

The most recent government initiative has been the enactment of the Bill 120, the Residents' Rights Act, 1991. The legislation confirms the mechanism to manage tenancy issues wherein the landlord of a care home must meet established provincial guidelines which protect residency. There is, however, no such legislative commitment regarding expectations or standards relating to care.

Outstanding issues. Our present concerns in respect to what has been accomplished to date relate to three areas:

(1) The failure of the domiciliary and emergency hostel review to create an accurate picture of domiciliary hostel residents and the current state of services available to them;

(2) The failure of the government to date to seize the initiative presented within the Lightman report, particularly in respect of support and protective services for vulnerable adults in care homes;

(3) The increased vulnerability of care home residents as a result of the failure of the current long-term care reform process to include care homes within the long-term care strategy.

(1) The hostel review. A major and fundamental flaw within the recent and prior reports concerning care homes is the failure to separate domiciliary and emergency hostel residents in both their quantitative and qualitative research. As a result, the service-intensive emergency hostel system has distorted the service picture of domiciliary hostels in general by suggesting more services than actually are provided.

The research was equally flawed in its failure to elicit adequate consumer input. For example, in one major report, seven residents from a single domiciliary hostel

constituted consumer input for the whole province, yet the report proceeded to make assumptions in respect to quality of service based on this totally inadequate consumer sampling.

Various reports repeatedly state the lack of recognition by the province of the key role of care homes in delivering extensive services as a primary issue, and that as a result, the per diem is inadequate. This statement is founded on the assumption that operators should be in the business of providing services.

It is our position that care home residents are a growing part of the community and should therefore have access to generic long-term care services, just as any other citizen. The Lightman report illustrates very clearly the inherent conflict between the profit motive and any inclination an operator may have to provide adequate support services.

In terms of funding, prior reports basically suggest giving more money to operators by way of purchase-of-service contracts with municipalities in exchange for provision of a specific package of services. No specific accountability measures are proposed other than a general statement that new mechanisms should be designed to monitor the effectiveness of the programs.

Our extensive experience in administering purchase-of-service agreements with care homes and in a setting regulated by a comprehensive municipal bylaw has shown us that direct enforcement of standards aid to ensure the delivery of adequate service. However, it is our position that apart from the provision of board and lodging, wherever possible, services should be handled by community agents other than the care home operators. Only then can integrity of the support services to vulnerable adults in care homes be protected.

Further, a conflict exists in respect of the administration of residents' personal needs allowances by care home operators. Recent changes to family benefits legislation have facilitated the payment of personal need allowances directly to the operators, as opposed to the residents. Windsor city council has recently petitioned the Minister of Community and Social Services to take action to redress the problematic situation. For its part, the Windsor department of social services has intervened to ensure that the direct delivery of personal needs allowance cheques to subsidized residents. However, there is nothing in place to protect the interests of private paying residents or care residents on a provincial scale.

Private paying residents are required to purchase additional costly services or service packages which may far exceed their needs, whereas the other community residents are able to access individual assessments as well as direct service provision from a community agency which operates under provincial regulation.

(2) Complementary legislation and support. The action of the government in expanding the Landlord and Tenant Act, the Rent Control Act and the Rental Housing Protection Act to cover care homes is consistent with the recommendations of the Lightman report in that it thereby recognizes care homes as residential, as opposed to institutional, facilities. With Bill 120, the government has taken a positive step in this direction. What should

follow, however, is the expansion of other pieces of existing legislation so as to ensure the safety and well-being of the residents, ie, the Ontario Building Code, the Ontario Fire Code, the Planning Act and the Health Protection and Promotion Act.

The government is to be lauded for ongoing action undertaken over the last two years in respect of the development of the Advocacy Act, the Consent to Treatment Act, and the Substitute Decisions Act. It is our position that further action must be taken in respect of the creation of protective services for vulnerable adults. The Lightman report has proposed a bill of rights, a rest homes tribunal and the mandatory reporting of abuse of vulnerable adults. In its submission to the commission of inquiry, Windsor city council went even further in proposing an adult protective services program.

(3) Long-term care reform. We do not ignore the fact that care home residents, as vulnerable adults, are medically frail or at risk by definition. It is essential therefore that all community health services be readily available to them as they are to other citizens who live at home. It would be essential that the single-access system under long-term care reform include care home residents.

We are dismayed, however, by the fact that the long-term care reform legislation to date has consistently excluded care home residents from their target group. We have been told that the needs of vulnerable adults in care homes are to be addressed by the government action in respect to the Lightman report. However, action to date, ie, Bill 120, can in no way compensate for the exclusion of care home residents from long-term care reform.

The virtual shelving of the medically at risk care home population in respect to any discussion of long-term care reform has been running parallel to increased efforts by hospital discharge planners to release long-term care facility-eligible individuals to care homes. Cutbacks in hospital budgets and bed closures are therefore compounding the problems associated with the frail elderly in care homes. The results of these policies and practices are increased serious occurrences, including accidental deaths, as a result of inappropriate placement of heavy care individuals in care homes.

As appropriately classified by the government, through expansion of the Landlord and Tenant Act and the Rent Control Act, care homes are residential, not health care facilities. All too often, in an attempt to control resident care, operators resort to inappropriate practice: for example, locked floors and utilization of physical and chemical restraints. Accordingly, heavy care individuals should have no place in care homes, yet our experience has proven otherwise, as demonstrated by continuous serious occurrence reports involving falls, medication errors, injuries, wanderings and other mishaps involving the frail elderly in care homes. While the Windsor bylaw regulates against admission of heavy care individuals into care homes, it is the operator's obligation to maintain appropriate admission standards. Regardless of this fact, it is our experience that operators accept inappropriate referrals.

As stated, hospital budget cutbacks and bed closures are compounding the problem, along with the fact that

many areas of the province, including the city of Windsor, are underallocated in respect to approved long-term care facility beds. While placement coordination services maintain total responsibility for placement in a long-term care facility, care homes are underregulated and open to abuse. The reality of the situation is that individuals are being warehoused in care homes, pending appropriate placement which may or may not materialize in time, resulting in the operation of bootleg nursing homes under the guise of care homes, totally condoned by the province.

In the early 1970s, the province began the depopulation of psychiatric facilities without appropriate community supports in place. Further depopulation is intended, and it is inexcusable to allow the same fiasco to occur by conscientiously excluding care homes from the long-term care continuum. From a municipal perspective, this is not only an abuse of our partnership; it results in the provincial downloading of responsibility for health care at municipal taxpayer expense.

Conclusion. While we recognize and applaud the government's recent initiatives as demonstrated by the advent of Bills 120 and 173, we strongly urge that further actions are required as follows:

(1) The placement of care homes under the umbrella of all other pertinent existing legislation in order to ensure the safety and wellbeing of all vulnerable residents;

(2) In the context of both the general welfare assistance hostel review and the long-term care reform, that the government ensure the separation of services from board and lodging in care homes, and further, that the delivery of services be under the auspices of long-term care legislation;

(3) That the province recognize the existence of the vulnerable adult population in Ontario and move to empower this group through the establishment of a proactive adult protective services program. This program will include provision to protect the personal and financial interests of vulnerable adults, which includes care home residents;

1430

(4) That the government enforce those provisions available under the Nursing Homes Act which prohibit the operation of an unlicensed long-term care facility or bootleg nursing home.

The Chair: Thank you. You got a tremendous amount into the time slot. We appreciate that, because you've also touched on some points which I don't think have come up as directly. We'll move to questioning.

Mr Ron Eddy (Brant-Haldimand): Thank you very much for your very effective presentation on behalf of individuals in care homes. This is a battle that's been waged by municipalities for many decades. I appreciate the detail that you've included and the recommendations or the conclusions that you've arrived at, because it does need consideration and should certainly be included, in my opinion. I certainly share with you the concern about the warehousing of individuals in inappropriate situations with all the problems, having been a member of a social services committee.

You have conclusions here and you stress those. You strongly urge that these actions, as required, be followed. I really have a question to the ministry, to respond to that, but I'd ask you to further elaborate on your conclusions, if you would.

Ms Howe: In terms of suggesting that care homes come under the umbrella of all pertinent existing legislation, if we just use for example the long-term care legislation, by the mere fact that care homes are not included in the continuum of long-term care, then the services that go along with long-term care are excluded from that population.

For example, where you may have placement coordination services looking at and assessing a client or a patient's needs and then determining what level of care they require, then they go into a system whereby they are slotted into the service that best meets their needs. In this situation what happens is, discharge planners don't have to go through the process of placement coordination, and they go out to for-profit homes in the community and they say, "We have someone for you."

These homes in the community are not nursing homes. They are regulated by a local, small bylaw that we're trying to do a very big job with. They don't have nurses on staff, they don't have proper staff-to-client ratios, and they have some of the most needy clients being placed through the back door. In addition to that, we have even found some discharge planners and operators going to the point where they're telling the family: "Don't go to social services. You're going to have to pay this yourself because they won't let you put that person in there."

It's a way to exclude us from the loop, because we don't have authority over the private-paying people in the same facilities, and we have had, in a one-month period in one home, two deaths where people have fallen from balconies, both private-paying residents.

So that's why we're very, very strong on the fact that the whole care continuum has to incorporate what have been traditionally called rest homes, lodging homes, hospitals or whatever, now called care homes. That's a really interesting terminology, the fact that the government has now called them care homes, without including them in the long-term care continuum. I think that's quite an anomaly.

Mr Eddy: Thank you very much for being so specific. It's important. Mr Chair, I would request the parliamentary assistant to respond. Is this being looked at? It should be. Is it?

Mr Wessenger: I am going to ask the ministry staff to elaborate on some of the issues raised. I don't have an expert here on Bill 120, but I understand it does give the ability of the resident to decline the services component of the package. So that is, I believe, in effect.

I certainly think long-term care services would be available to residents of care homes under this bill, but perhaps what you're referring to is more of a residential care package.

The Chair: Mr Quirt, and then, Ms Howe, we can continue that once he's finished.

Mr Quirt: I'll try to respond as quickly as I can.

People who live in unregulated rest and retirement homes are eligible for services from the MSA if those services aren't already part of the package of services they've purchased. So, for example, if you lived in a rest and retirement home and had your room cleaned and your bed made and your meals provided, you'd be eligible for things like a visiting nurse or a visiting therapist, but you wouldn't be eligible for a visiting homemaker because you've already paid for that type of service in your living situation. So those clients are eligible who do receive home care services now and they'd continue to receive those professional services.

With respect to Bill 120, you're quite right that the measures taken to date by the government provincially have not included the inspection and monitoring of private sector rest and retirement homes, the care provided there. The government's approach was one of providing consumer protection to the people purchasing those services in the private sector by extending the provisions of housing protection to them. Mr Lightman's report, as I recall, recommended kind of a consumer protection approach on the care side of it. But you're right, there was no move to monitor and inspect the care provided at either the municipal or provincial levels.

The only other point I'd mention in response to your recommendations is that the Nursing Homes Act currently prohibits someone from misrepresenting a rest and retirement home, using the term "extended care nursing home" and implying to the public that it's a publicly funded and licensed facility. But you're not breaking the law by offering similar kinds of services in a private residential facility that are publicly funded in a nursing home.

Ms Howe: Just in terms of the last remark first, I think this probably is one area that is tremendously misunderstood by the public. They don't really understand, and sometimes I don't think that doctors really understand what the difference is between the different levels of homes and what they provide. As a result of that, the public can be lulled into complacency by thinking that their loved ones are being placed in a facility where monitoring is going on and in fact it's not. I hear what you're saying, but I think in reality there's a major problem out there.

Mr Quirt: I think you've made a good point about the placement coordination services. Now that they're available across the province, certainly people will have a better chance of understanding which facilities are publicly funded and supervised. Clearly, all placement coordinators know that their obligation is to assess eligibility and authorize admission to publicly funded and supervised facilities: nursing homes and homes for the aged.

Often they do provide general information to families about the private sector options in their community, but they're not involved in placement in those facilities per se. I hope with PCS across the province, consumers will be better aware of the options available to them and the extent to which the province is involved in protecting their interests in those options.

The Chair: One comment and then, I regret again,

we're going to have to move on.

Ms Peggy Davis: Okay, just one comment. I think the gap exists in the discharge of people by other than placement coordination services. Discharge planners in hospitals especially are not required to refer a long-term-care-eligible patient through placement coordination services. They're able to make a direct placement in a retirement home.

Just to comment on the nursing home issue, if you open the yellow pages in any phone book and look under "retirement homes" or "rest homes" or maybe "care homes," you'll see advertisements and you'll see advertised 24-hour nursing care. You'll see ads that really project a health care facility. That's all I wanted to say.

The Chair: Thank you very much. I think, as I said before, you have itemized some concerns that we haven't discussed directly. That is very helpful and we appreciate you coming to London from Windsor. It's good to see you both again.

INDEPENDENT LIVING CENTRE, LONDON AND AREA

The Chair: We then move to our next presenter, from the Independent Living Centre in London.

Mr Steve Balcom: Good afternoon. My name is Steve Balcom and I'm president of a fledgling Independent Living Centre here in London. Thank you for the opportunity of coming and speaking with you today.

As I was going over and reviewing my notes, I was debating whether to read them verbatim or paraphrase. I'm going to do a little of both, so bear with me to make sure I don't miss some of the points.

1440

The Chair: There is time, so please feel free to make sure you get all the key points on the record.

Mr Balcom: Okay. Thank you.

The Independent Living Centre of London and Area, otherwise affectionately known as ILCLA, represents the voice of London and area's physically disabled consumers, or consumers with physical disabilities, and their needs within and out of the service system.

We have reviewed Bill 173, the Long-Term Care Act, and for our purposes the format that we chose to follow is more of questions and answers within the context of the legislation itself, or the pending legislation. So I won't be quoting paragraphs and all that stuff, but it will be apparent to those who have the act with them where I will be referring to.

Definitions: Ah, yes, definitions. In reviewing this section we noted an obvious absence of several important definitions. The definitions that we believe are lacking are:

"Individual," in our definition, one person, one specific set of circumstances, personalized;

"Consumer," an individual who utilizes long-term care functional services, a service user who is aged or has one or more disabilities;

"Agency," a not-for-profit corporation, a cooperative, municipality, board of health or band council.

I must ask, given the opportunity, can somebody please

explain to me, from the previous presentation, what a care facility is as was presented in the last presentation? By my definition of where I live, it is either a support-service living unit or someone's apartment, not a care facility, in reference to where long-term care is. I would appreciate at some point a definition of what your intent is behind that, the meaning of the term so that I can understand it.

Question, and this relates back to the definitions: Will the delineation of "individual," "consumer" and "agency" be added to the bill's roster of definitions so that we're all playing with the same jargon? I have a distinct feeling, again, that what we mean by consumer and what is reflected from the Ministry of Health side as a consumer of service potentially can be two vastly different things.

Bill of rights: This section of the Long-Term Care Act is worthy of the praise being circulated by consumers within the system, as has been reflected by earlier speakers. It is the first time some of the consumers' germane or more common issues have been noted within the context of legislation, outside of the Charter of Rights and Freedoms, and we commend the act for this.

However, we are disappointed that some organizations are trying to use the term "rights" in a different context. We're running up against service providers trying to mitigate our rights and protections under, for instance, the Landlord and Tenant Act, which I believe Bill 120 speaks to specifically, and to my mind and to a lot of adults with disabilities, we are tenants in our own units, however they may be funded.

One question raised by this act is that the service provider may refuse access to records, and, if appealed, the agency may present a medical affidavit stating the complainant is incapable of attending the review, which will be accepted.

I've got to be honest; that's one area of the act that's very ambiguous, and this really concerns us and a lot of persons with disabilities. This double jeopardy situation places the consumer fully behind the eight ball. In other words, potentially it gives us no recourse as it's currently written.

ILCLA supports the consumer being present at all such reviews, every step along the way. We further support the bill of rights in this Long-Term Care Act to place an onus on the ministry to create a process by which an individual could count upon a review postponement until he or she can be present, or to provide the services required to permit the consumer to participate. That means that if they required text in forms other than written, it be provided to them; if they need an advocate to be there on their behalf, they be allowed that right.

A supplementary question revolves around this same issue about information access. This I believe I've covered under the consumer's right to have information presented in whatever form they may best be able to understand, whether that's Braille, whether that's interpreter or whatever that may be, in the appeals process so they can be aware of what is going on and be made to understand.

Within the act itself there's a statement that appears analogous to almost an umbrella statement for service providers in their responsibility to consumers. This occurs when the act states that consumers must accept the good intentions of service providers and their staff. Under the bill of rights, good intentions mean little.

Further, to date Bill 173 addresses the importance of complaint processes. However, there are no complaints featured within Bill 173 for that provision. Without it being clearly stated to them, the consumers must be aware of what their rights are. You're presuming that the consumer already has that knowledge base.

ILCLA believes that this is not the way to approach policy-making. A far more effective approach would be to work with consumers to establish a user-friendly, consistent complaint process which does not rely upon good intentions. Questions that we have are: Will consumer rights truly be protected? Will standardized rights enforcement criteria be established? Will information be provided to consumers in appropriate mediums, which was what I was referring to earlier in terms of alternative formats other than written form? Will a consistent complaint process be established?

1450

Governance: Bill 173 states that an appointed MSA or approved agency will process, review, refer or assign individuals to required services, and in any one community there may be one or perhaps a dozen or more MSAs. There are no restrictions on their numbers and no clear criteria for them to meet. Membership and other regulatory decision-making is left to the appointed non-representative district health councils. I believe this was referred to by an earlier presentation. The only requirement currently requisite for agency participants is that they must reflect the diversity of the community. However, diversity is not defined except as an unspecified amount of representation. I've got to be honest: Those of us who have been doing advocacy in the community for a number of years have tried to get our names submitted to be on district health councils and so far, to this point, we've been pretty unsuccessful.

Obvious in their absence from all factions cited in the act are consumer representative groups. Equally obvious is the absence of choice in service assessment criteria. These are particularly important points when one considers that the decisions made by the MSAs, district health councils, consent and custody review boards and health services review boards could have serious implications for those desperately seeking services. You've got to realize that every one of those boards will impact directly on the individual consumers.

Questions:

Will consumers with disabilities have suitable representation on the DHCs, MSAs, consent and custody review boards and all related decision review appeal boards?

Will there be service overlaps within MSAs? I'm sure there will be.

Are the mandatory services offered in or through an MSA deemed to be the baseline services of all Ontarians, because right now there is no clearly defined baseline.

Will consumer choice be included in the assessment referral process? Because right now there is none. MSAs are charged with referral to more appropriate services. However, this may generate a large pocket of people no one can or will service due to funding limitations and staffing caps. Where will consumers go, except to the infamous unregulated waiting lists? I think there's been enough referral to that earlier this afternoon. These have never proven an effective service methodology. The discordant nature of these modalities in availability and waiting lists have already proven to be non-beneficial. Limited service availability requires greater consideration before this act receives final reading.

There's difficulty in comprehending the lack of a standardized appeal procedure within MSAs, DHCs and all other approved agencies. I've got to be honest: That's one of the issues that we find very bothersome. People who are refused service or provided less service than they believe they require or who are facing service termination must have access to a prompt, fair appeals process. ILCLA urges the minister to address this deficiency quickly and establish a user-friendly process for consumers of services.

Again, another question: What happens to consumers when the referral agency has no funds with which to provide service? Will there be an alternative to a waiting list?

Will there be standardized appeal mechanisms in place prior to passage of Bill 173? Because right now, I've got to be honest, we feel that as consumers we don't have a voice. In fact, more to the point, we don't have a voice.

Quality assurance: Quality assurance is a necessity. Bill 173 to date fails to tell us what the quality assurances are. ILCLA wishes to ascertain precisely which standards will be utilized for comparison, how they were selected, who will monitor the compliance. That's a biggie. Who are they or the service providers that they're going to be making decisions that directly impact on consumers' lives? It seems to us and me that the consumer got lost in the process somewhere along the way. ILCLA further believes this information should be utilized in the program evaluation process. We do not believe it is appropriate to ask the lion to be the gatekeeper.

Therefore, an independent agent outside of the system would be necessary to ensure compliance and recording of this information; in other words, an independent source. You've got to remember, those to whom the money will be flowing have a vested interest in maintaining the status quo. Quality assurances are better defined by policy experts in conjunction with the consumers.

Questions: Will the quality assurance criteria be in place prior to the passage of Bill 173? Will the assurances be reflective of consumer input? Will quality assurance be utilized as an evaluative tool? Lastly, will an independent agent monitor the compliance of quality assurance?

In summary, the Long-Term Care Act is to ensure a wide range of services available to people in their homes; improve quality of service; ensure a person's needs and preferences are considered; not to be assessed once again, a big one—some assessments are necessary but in con-

junction with the individual consumer—promote equitable access to service; promote efficient management of resources; encourage local community involvement, management and delivery of service through the MSA.

Independent Living Centre, London and Area, will not feel confident of this action potential without receiving the supplementary responses to our inquiries. Government is shifting people, programs and policies quickly. We want assurances that decision-makers have seriously considered the important issues which impact upon persons with disabilities. Thank you.

The Chair: Thank you very much. I know you raised a couple of questions where you wanted clarification, and I will ask the parliamentary assistant to do that, but first Mr Wilson for any questions.

1500

Mr Jim Wilson: Thank you, Steve, for a very excellent brief. In fact your reputation, I want you to know, as an advocate does precede you. It's a pleasure to be here with my colleague Dianne Cunningham to see you in action at first hand as Health critic for my party. I thank you for a very informative brief.

I think perhaps, Mr Chairman, in addition to the parliamentary assistant making a couple of comments now, there are a number of very good questions. I would ask the parliamentary assistant if he would take it upon himself to ensure that Steve and his group receive a detailed response to all of the questions there, and particularly the latter ones with respect to quality assurance, because what came to mind, Steve, when you were talking about that is that we kind of have the fox in charge of the henhouse with respect to who will monitor quality insurance and ensure it. That's a point that actually hadn't been brought to our attention previously, I don't think anyway.

I did want to ask you one question, though, with respect to the bill of rights, because I think you made a number of good points about it. In your reading of the bill, are there any teeth in the legislation to back up all of the rights?

Mr Balcom: To my recollection, there is reference to the bill of rights but it doesn't extend it, it's not reinforced into individual rights. There's vague reference to it in that people have access to it. It's nice to know that those of us who lobbied to get it in place have it acknowledged that it exists, but that's as far as—there is no—well, two things. In terms of the legislation as it now exists, there is no empowerment, there is no inclusion of individual rights within the context of the Human Rights Code itself and how that would be implemented in any complaints process, or where it would impact or how it would be enforced, or any direct reference to it other than a very generalized acknowledgement of the act itself, which gets back to complaints and grievances and the whole bit.

Mr Wessinger: Thank you very much for your presentation. You certainly have raised a large number of questions. I will request ministry staff to provide you a comprehensive reply to your questions, but I think it might help if we had some clarification perhaps from

legal counsel on some of the issues that relate to the legislation.

Ms Czukar: Initially you were discussing the issue of the definition of "care home" and whether there are common definitions. Just to clarify that, that definition of "care home" in Bill 120, which changes definitions in the Landlord and Tenant Act and the Rental Housing Protection Act, is for the purpose of those acts alone and doesn't define them for purposes of long-term care. They do that in order to clarify that people who live in a place, a home, longer than six months, and even if there is a care relationship, have the rights of any other tenant under the Landlord and Tenant Act and also the Rental Housing Protection Act. It's not for the purpose of defining the care component; it's for the purpose of defining the tenancy and the rights that people have as tenants.

The Chair: Mr Malkowski has a point of clarification which I'll deal with now.

Mr Gary Malkowski (York East): Yes, just on a point of clarification, in relation to a formal mechanism for consumers, is there a guarantee specifically that the disabled community will be involved in terms of a mechanism for feedback and for involvement in this whole process?

Mr Wessinger: I'll ask Mr Quirt to reply to that one.

Mr Quirt: Specifically with respect to attendant care outreach programs, there is a commitment that the consumers of those programs will decide whether they wish to have the government continue to fund an independent attendant care outreach program or whether they wish to receive their attendant outreach services from employees of the multiservice agency. It would fall to district health councils. I think a couple may have addressed this question already, but district health councils will have to advise the minister in the near future, canvass consumers of those programs and advise the minister as to the wishes of consumers.

With respect to the supportive housing programs for people with physical disabilities, where we provide funding for the support services, intentionally our preference is to fund a separate agency to deliver support services from the organization that is the landlord to the tenants in the building. In those situations, the multiservice agency would not have any involvement in the funding arrangement. The funding would go directly to the support service provider. Clearly the multiservice agency may refer people who could avail themselves of those services, but they would not be part of the loop, if you like, in terms of that relationship between the provider agency and the government.

The Chair: Thank you very much for coming before the committee today, as always.

ONTARIO COMMUNITY SUPPORT ASSOCIATION, AREAS 1, 2 AND 3

The Chair: I call on the representatives from the Ontario Community Support Association, areas 1, 2 and 3, if they would be good enough to come forward. Welcome to the committee. We have a copy of your submission. If you would be good enough to introduce

yourselves, then please go ahead.

Ms Sue Hillis: Good afternoon and thank you for the opportunity to present today. I'm Sue Hillis. I'm the director from area 2, and this is Heather Richardson, the director from area 3. Our presentation will begin today with a brief overview of who we are and we'll follow this with our key areas of concern with the legislation.

The Ontario Community Support Association is an organization of direct providers of community-based services. Our primary purpose is to support, promote and represent the interests of community-based not-for-profit health and social service agencies across Ontario. In over 300 member agencies across the province, our organization provides community support services to the elderly, people with a disability and those convalescing from an illness to enable them to live safely and happily at home. Over 10,000 dedicated staff and 45,000 active hands-on volunteers work diligently to provide a wide range of services. Many of our volunteers are seniors themselves. In 1993 these volunteers donated over 1.2 million hours of service.

Each year more than 600,000 Ontario residents receive help from community support service programs. OCSA tries to work with governments, related associations, the general public and the private sector to develop innovative and responsive strategies to expand community support services and to support the efforts of seniors and others with special needs to remain independent in their homes.

OCSA is divided into 15 areas, which form the foundation of the association. Through this area structure members are able to have an equal voice in the association while allowing each area the flexibility to respond to the needs identified by its own membership.

Today we are presenting on behalf of areas 1, 2 and 3, which encompasses Essex, Kent, Lambton, Elgin, Middlesex, Oxford, Perth, Huron, Bruce, Grey, Dufferin, Waterloo and Wellington county member agencies, approximately 80 agencies, a good cross-section of both urban and rural.

The membership of OCSA supports several aspects of Bill 173, An Act respecting Long-term Care. We endorse the principles and values enunciated in Bill 173. It's been these principles that have guided our response today.

We support not-for-profit service delivery where the principles of community-based planning, equity of access and equality of services prevail. We are committed to the development and implementation of standards of care and the continual improvement in the level of service quality.

Based on the input from those member agencies I've mentioned before, we would like to present area 1, 2 and 3's five key areas of concern with this legislation. They include the following: areas not covered in the legislation; the regulations; volunteerism in the reformed long-term care system; multiservice agencies; and categories of services. Heather Richardson will present a more detailed assessment of these issues within each area of concern and suggest recommended strategies for improving the legislation.

Ms Heather Richardson: Areas of concern, areas not covered in the legislation: In the document Partnerships and Long-Term Care: Guidelines for the Establishment of Multi-Service Agencies, released in September 1993, messages regarding the perceived preferential treatment of unionized employees in the new MSA became apparent. Subsequently, in Bill 173 there were no references regarding the protection of not-for-profit community-based employees as a result of implementation of long-term care reform.

Long-term care reform acknowledges the need for experienced, trained staff for the provision of services, yet the proposed process for development of multiservice agencies, along with social contract reductions and constrained finances, all currently have or will potentially have a negative impact on employment in the broader socio-healthcare sector.

Although there are similarities between clients in institutional settings and those in the community, the environments are quite different. Therefore, special consideration is required when transferring staff from facilities to community-based agencies. For example, there are differences in the skill sets and goals of care, or methods of achieving those goals.

A forgotten group of employees who work through brokerage agencies should have their experience recognized in this process.

The community support sector consists of over 10,000 employees who are experienced and trained in the care and delivery of services. These staff have worked for years at low wages and minimal benefits with a strong commitment and loyalty to providing quality services. Unionized employees in the broader socio-healthcare sector are demanding priority employment in the community sector. Our sector is predominately non-unionized and thus less able to voice concerns than organized labour bodies.

There will be significant human resource issues which will require expertise, time and financial resources in order to be addressed successfully.

OCSA recommends that client continuity and respect for the relationships between existing employees and consumers of service should be paramount. Consequently, employee transfers to new agencies should be seamless, with no break in employment or client service.

All employees of not-for-profit community support service agencies should be guaranteed comparable positions in the new service delivery structures, without loss of seniority. Otherwise, in all community support sector hiring, displaced employees from not-for-profit community sector support agencies should be given priority over other socio-health sector employees.

General regulations: It is our view that Bill 173 has taken an overly prescriptive approach to the provision of community-based services. Some 42 regulations have yet to be produced. Much is unknown at this point, yet the areas to be covered appear to be quite prescriptive. It is difficult to present a response to the legislation in the absence of the detailed information which would be in the regulations.

Bill 173 allows for the provision of regulations to be retroactive. However, MSAs will be developed over a period of four years. Consequently, it will not be feasible in certain instances to make the regulations retroactive.

The province is moving quickly to put MSAs into practice, yet major components need to be put into place; for example, eligibility criteria, program standards, MSA guidelines, regulations. OCSA says that we must be actively involved in producing and approving the regulations to be developed in Bill 173. Furthermore, OCSA recommends that extreme caution needs to be applied in setting retroactive dates of application.

Volunteerism: In addition to their valuable work in service provision, a significant amount of money is made available for services as a direct result of the fund-raising efforts of volunteers. If volunteers are not properly maintained, costs will skyrocket; thus, MSAs will not be cost-efficient and the ability to meet existing consumer needs will be jeopardized.

There is a lack of detailed planning regarding volunteers and long-term care, even though there is a concern about an inadequate number of volunteers currently to support the expansion of programs and services. We recommend that volunteers should be kept well informed and actively participate in the change process in the implementation of long-term care reform. Furthermore, sufficient resources to support a volunteer management structure which includes recruitment, training, scheduling, supervision, retention, recognition and expense reimbursement of volunteers at the natural community level should be provided on an ongoing basis. Volunteers are motivated by an array of factors and cannot be shifted organizationally away from their work without risk of loss. Therefore, it is absolutely vital to maintain the linkages between volunteer tasks, their communities and the agency staff that sustain them.

Multiservice agencies: It is essential that there be sufficient flexibility to allow communities to develop an MSA system to meet local needs. It is unclear what the final MSA model will look like in each community until the community planning process is over. Consequently, it is premature to assume that the same model will meet the needs of all residents in Ontario.

One-stop or single access does not necessarily mean that all services and care providers have to be assembled under one roof or that consumers have only one point of contact in a community. It may, for example, be achieved by a functional integration of information, referral, assessment, case management, service delivery and follow-up in multiple locations. On the other hand, we must ensure the client does not become discouraged by being referred to various services, as is currently the practice. OCSA believes that MSAs must not be allowed to develop into large bureaucratic organizations. They must be small enough to be able to be responsive to local community needs.

Improved coordination and access to available services are highly desirable. Close coordination will be needed if there is more than one point of contact in a community. Communication among providers is key. Functional integration of information could be achieved through

electronic communication systems and/or by combining physical locations for smaller community support agencies to achieve economy of finances and volunteers.

OCSA recommends that if functional integration is pursued, top priority must be given to ensuring there is an effective computerized information network in place. This must include a financial commitment to design, hardware, software, training and support.

Categories of service: The separation/distinction between community support services, homemaking, personal support services and professional services reinforces a hierarchy of services ultimately geared to medical needs rather than fostering a continuum of care. It reinforces a split between health and social services and moves away from wellness, health maintenance and prevention measures. This is inconsistent with the purposes of the act. It will be confusing to the client and the case manager, who will be pressured to approve the need for personal care.

The distinction between personal support services and homemaking services appears to be contrary to the current trend to develop a "generic" worker which would combine health care aides, homemakers, home support workers, home helpers and attendant care workers. In most agencies, both personal support services and homemaking, as defined in the act, are provided by the same person. These services are provided concurrently and this worker will be the recipient of the recently developed training program. The inclusion of these two services separately in the legislation is a major step backwards and could interfere with the development of a generic worker.

There are also concerns about how these two services will be operationalized. This separation will be an administrative nightmare for the service provider or approved agency. For example, how does the service provider manage the client who requires a bath (personal support services) and laundry, shopping and housecleaning (homemaking)? Both services are important in terms of maintaining the client's independence in their home. Will the time be prorated?

New terminology is being used, and initially this may lead to some confusion in the community. "Personal support services" was known as "homemaking." "Homemaking" is being used to describe tasks previously referred to as "home help." It is recognized that the terminology currently being used varies considerably across the province and there is a need to have standardized definitions. A definition of services to be provided by MSAs must allow for flexibility to encourage the development of innovative programs, which can be more effectively and efficiently developed through a community development process. OCSA recommends that the artificial distinction between homemaking and personal support services be ended by combining them. OCSA would like to be involved in the development of a new term to describe the service.

1520

The user fee issue should remain separate and not be included in this legislation.

It is important that a comprehensive communication plan to educate consumers and service providers on the changes in the system be developed. Change is often difficult and confusing, especially for a consumer.

Ms Hillis: We applaud the leadership demonstrated by the provincial government through the development of Bill 173, which establishes the key building block in the foundation of the new long-term care system. We appreciate the commitment to building partnerships with the community to effectively plan and implement meaningful change.

Given the time constraints for today's presentation, we have given you a more thorough summary of our concerns in writing from our area. As well, I understand you also have a copy of the full OCSA membership response, which presents areas of Bill 173 that we endorse, our areas of concern and recommendations in much greater detail. We look forward to working in continued partnership with the government and our community colleagues to bring about the redirection of the long-term care system and will be happy to answer any questions that you might have about area 1, 2 and 3's concerns about the legislation.

The Vice-Chair (Mr Ron Eddy): Thank you for your presentation. A question by Ms Haslam, please.

Mrs Haslam: I was present when this was presented to us in another area. I didn't get to make any comments or ask questions at that time, so I'm certainly going to take advantage of it now.

Number one, I firmly believe in what you're talking about when you talk about the computerization and those kinds of networks that are so important out there. That takes me back to one of your previous comments on page 5, where you said providers have to be assembled under one roof. That's not what the legislation is saying. We're not saying that you have to build a building and move everybody under one roof; we're talking about networking of services.

I don't know why they didn't take my advice a long time ago when I said instead of naming it MSA, why didn't they call it the area services coordination, and then it could be called ASC, and your seniors, then, when they have questions, don't have to call an MSA; they could call ASC. Nobody ever listens to me with these acronyms. What can I tell you?

The second thing I wanted to mention under your presentation is on page 3 when you talk about reductions and constraints of finances. I just wanted to remind you that in 1990-91, long-term care community funding was \$550 million. In 1993-94, that's been expanded by 54%, to \$850 million, and by the fiscal year 1994-95, we will be spending over \$1 billion in long-term care community-based services. I think that has to be out there in the public so they know that those moneys are being put into the community.

Which brings me back to page 5 and the volunteer portion of your presentation. It's an area that I take a great interest in. You talk about a volunteer management structure. I don't know if you know there is going to be a series of forums cosponsored by the ministry and the

Association of District Health Councils and the United Ways of Ontario which will examine volunteer recruitment, retention and fund-raising in the new system.

When you come with concerns about that, what shape do you see it taking? What shape do you see that volunteer structure, what form, the number of people and how it might be managed, and what suggestions would you give to your local process? It's a local process of putting in your MSA. It's the local input that will address how that looks in your community. What would you be saying on that committee when you discuss how to keep the volunteers active in your MSA?

Ms Hillis: I guess one of the big points that would strike me right off is that it's really important for volunteers to be able to identify with what service they're providing.

Mrs Haslam: Like program sections, yes.

Ms Hillis: By program or by service or whatever, because people often volunteer for specific things for personal reasons.

Mrs Haslam: Sometimes.

Ms Hillis: We find that often in several of our services, anyway. So I think it's really important that they're brought along very slowly, that throughout the whole process they're asked what's most important to them, and that they can retain some identity with the program as it progresses through to whatever structure it's going to be in the future. I think unless we bring them along slowly throughout the process, we will lose them along the way.

Mrs Haslam: So give them as much input as possible into how a structure manages and funds them, if necessary, and trains them.

Ms Richardson: I would like to make a comment to the amount of money that is being put into the system. Certainly, looking at the demographics that we're going to face over the next century coming to us, we are going to have to put considerable resources in. It is understandable that this is a beginning of a curve of resources; however, as we have noted in previous presentations, the waiting lists are not getting shorter, because of course the demographic issue does face us very strongly.

Also, as you may know, IHP in many areas is capped. There is the possibility that supplemental budgets are not going to be filled in terms of home care. And of course, as you know, the social contract has meant—although primarily our concern is for the clients as it relates to those supplemental budgets and IHP caps and waiting lists, certainly there is a notation regarding staff, that most of the staff are lower paid than in the hospital sector and yet they are not having increasing remuneration because of the social contract. So there might be a thought in terms of the moneys going into the system being demanded by the demographic curve.

The Vice-Chair: Thank you for your presentation.

MIDDLESEX-LONDON HEALTH UNIT

The Vice-Chair: The next presentation will be made by the medical officer of health of the Middlesex-London Health Unit. Welcome to the committee.

Dr Graham Pollett: Thank you, Mr Chairman, members of the committee. My name is Graham Pollett. I'm the medical officer of health for the Middlesex-London Health Unit. With me today are Councillor Ted Wernham, a member of the board of health, and Mrs Patricia Coderre, the director of the home care program. We appreciate having this opportunity to contribute to the review of Bill 173.

To begin with, I would like to provide you with some background information regarding the Middlesex-London Health Unit. The Middlesex-London Health Unit was formed in 1971, following the merger of the city of London and a number of Middlesex county health units under one board of health. In 1972, the new board accepted responsibility for the school health service, which had previously been provided by the city of London board of education. The home care program, which had been initially administered in this area by the Victorian Order of Nurses, became the responsibility of the board of health in 1980 and has functioned as a division of the health unit since that time. A four-year accreditation award, the maximum given by the Ontario Council on Community Health Accreditation, was granted to this health unit in 1993.

The catchment area for this health unit is, as its name implies, the county of Middlesex and the city of London. This area includes a population of approximately 320,000 people. The health unit consists of a multidisciplinary staff of 310 operating out of a main office in London and a satellite office in Strathroy.

The Middlesex-London Health Unit is governed by an autonomous board of health, as opposed to many Ontario health units that are part of a municipal structure. Presently, membership on the board consists of three city of London council appointees, three Middlesex county council appointees and two provincial appointees. The duties and responsibilities of a board of health are defined in the Health Protection and Promotion Act. This act was proclaimed on July 1, 1984, and it replaced the Public Health Act.

1530

Section 5 of the Health Protection and Promotion Act defines seven programs and service areas which every board of health must provide or ensure the provision of. These include community sanitation, control of communicable diseases, preventive dentistry, family health, nutrition services, public health education and home care services.

Prior to and following the proclamation of the Health Protection and Promotion Act, this health unit has been mandated to provide home care services within Middlesex-London.

The Middlesex-London board of health is on record as strongly supporting the principles and goals of long-term care reform stated in the ministries of Health, Community and Social Services and Citizenship document entitled *Partnerships in Long-Term Care: A New Way to Plan, Manage and Deliver Services and Community Support—Guidelines for the Establishment of Multiservice Agencies*.

Upon review of these principles and goals, and based on our history and legislated mandate for service delivery, the board of health has initiated action with the objective of representing this community as a multiservice agency. The first step in this process was the development of a Middlesex-London Health Unit multiservice agency model. We have included a description of this model with copies of our submission.

Bill 173 defines the criteria for establishing and operating multiservice agencies. The Middlesex-London board of health has identified two concerns which we will address today. The first relates to the establishment of multiservice agencies and the second concerns an operating dimension.

Part VI, section 11, subsection (3) of Bill 173 reads as follows:

"Before designating a municipality or a board of health as a multiservice agency for a geographic area, the minister shall consider the suitability of all other approved agencies in the geographic area for designation as multiservice agencies."

In effect, this subsection disqualifies health units from becoming a multiservice agency. In the case of this health unit, the opportunity to compete is essentially eliminated because there are so many local agencies which must be given prior consideration.

Why is this subsection included in this bill? What direction is it giving to those making decisions regarding the establishment of multiservice agencies? And what message is it giving to boards of health?

As mentioned, this board of health has been administering the home care program for the past 14 years. In so doing, it has been responsible for providing those community services defined under Bill 173 as homemaking services, personal support services and professional services. In addition, staff of the Middlesex-London Health Unit home care program administer a \$1-million meal services budget as well as having, on an ongoing basis, direct contact with providers of the remaining services designated under community support services.

Similarly, 32 of the 38 home care programs, 32 of the 38 integrated homemaker programs, 32 of the 38 assistive devices programs and 12 of the 36 placement coordination services are administered provincially by public health units.

At no time over the past 14 years has this board of health been advised by the Ministry of Health of any dissatisfaction or concern with the manner in which the services we deliver were being administered. We are left at a loss to explain this situation.

There is no other community board in Middlesex-London that has the experience for administering the range and volume of community-based services that this board of health has. There is no other existing community-based agency in Middlesex-London whose staff have the expertise for administering the range and volume of community services that staff of the Middlesex-London Health Unit have. There is no other community-based agency that integrates health promotion and protection, disease prevention and treatment services at the commun-

ity level for as large a population as this health unit does.

As a board and as staff, we are left in the worst possible situation: not knowing the reasons for our apparent exclusion and therefore not able to directly address the rationale behind this decision. Recognizing this dilemma, we would like to briefly speak to a number of issues which could have contributed to the wording of section 11, subsection (3).

The first pertains to the composition of boards of a multiservice agency. Currently, the membership of most, if not all, boards of health, including the Middlesex-London board of health, does not meet the requirements for those of multiservice agencies. It is important to remember that boards of health and health units are creations of the provincial government.

The composition of a board of health is defined by statute: the Health Protection and Promotion Act. Changing the sections of this act related to board composition would achieve the community involvement objectives intended for multiservice agency boards.

Secondly, if there is a concern that health units are headed by physicians, a change in the section of the Health Protection and Promotion Act designating a physician as the chief executive officer could likewise be made.

The hospital sector is an example where this change was long ago instituted. Further, it is important to remember that physicians make up less than one half of 1% of the multidisciplinary staff complement of any health unit.

An opinion expressed by some is that health units practise the medical model and, for this reason, they should not be considered eligible as a multiservice agency. For those of us in health units, this is particularly upsetting. Nothing could be further from the truth in 1994.

Public health has been instrumental in initiating the practice of health promotion, where the health care provider is seen as a facilitator to assist the community and its member to achieve their health goals, as opposed to prescribing actions or treatments for people.

Advocating with and for clients has been a part of public health since its inception, as has the focus on disease prevention and health protection. But over the past 20 years, there has been a dramatic shift to a practice based mainly on health promotion principles. In fact, other community agencies and institutions are adopting the health promotion approach based on the leadership provided by public health.

A final point which may have influenced those drafting section 11, subsection (3), is the perception on the part of some people that the health unit, in particular the staff of the home care program, are bound by a bureaucratic approach to administering programs and services.

In the home care program, we have been given the task of implementing Ministry of Health policies, procedures and eligibility criteria. We have done this and continue to do so in a professional, compassionate manner. This is a job that is not always easy and is rarely appreciated, especially by those who find fault with the service.

The need for this role will not change in a multiservice agency. No matter who makes the decisions at the local level regarding the distribution of scarce resources, there will always have to be a messenger charged with delivering and implementing those decisions. Then, as now, don't shoot the messenger.

Are any of these factors the reason behind the inclusion of section 11, subsection (3)? Is it a lack of understanding of public health philosophy or how public health units operate? We simply don't know.

Whatever the reasons, it is our opinion that Bill 173 completely ignores a proven, well-organized system already in place for the delivery of long-term care services. Rather than building upon the strengths of this system and addressing its limitations, Bill 173 effectively eliminates public health units from being considered as multiservice agencies.

We therefore urge you to reword section 11, subsection (3), such that all community-based agencies will be given equal opportunity to be designated as a multiservice agency, or eliminate subsection (3) entirely.

The second concern we have with Bill 173 relates to the operation of multiservice agencies as defined in section 13. This section will result in the integration of a minimum of 80% of service providers as employees of a multiservice agency. Non-profit and for-profit service provider agencies will be left to compete for the remaining 20% of the amount budgeted for any one of the four categories of community services. Even this amount of expenditure for external purchase of service is not secure, being at the discretion of each multiservice agency board.

1540

As a result, most agencies providing services under the current home care program will not be viable operations and those remaining will be reduced essentially to the role of temporary employment agencies. This, in effect, will greatly reduce opportunities offered by a competitive marketplace.

Further, in our opinion, this situation represents unfair treatment for those non-profit and for-profit agencies which have provided and continue to provide an essential component of the home care program. Many of these agencies in the non-profit sector have a long and distinguished record of public service. In addition, within Middlesex-London, the home care program has encouraged and fostered the growth of a number of for-profit agencies simply because the non-profit sector was unable to handle the volume of service delivery required.

We contend that each multiservice agency should focus on coordination and administration of a one-stop access mode of long-term care service delivery, but leave the actual hands-on service provision to those agencies with proven expertise in this area.

We therefore request that section 13 of Bill 173 be deleted. The current wording of section 12 allows for flexibility in the type of approach chosen by each multiservice agency board; that is, contract for service, integration of service provision or a combination of these.

In conclusion, we wish to thank you for the opportunity to appear before you. While we are generally in

support of Bill 173, we have identified two areas which cause us concern as a community-based health agency currently providing long-term care services. We hope you will give serious consideration to our concerns in your final recommendations for changes to this legislation. Thank you.

The Vice-Chair: Is there any other comment from either of the others? Questions? Mrs Caplan.

Mrs Caplan: Excellent presentation. I thought of a couple of other things that you hadn't mentioned and that I would like to put on the record, given some of my prior life. I always found that the boards of health and the health units, public health generally, had an excellent leadership role in outcome evaluation, the kind of quality development in their programming based on analysis that provided models for other service providers.

I just thought I'd mention that, because it wasn't in your presentation and it is something that the boards of health were ahead of everybody else on. When we were looking at bringing the notion of quality assurance and continuous improvement into health policy and health reform, the boards of health did provide an excellent model.

I think your question deserves an answer and I'm going to ask the parliamentary assistant, since this is a matter of policy, if he could tell us why the legislation has effectively excluded, or at least if not totally exclude, discriminated against the ability of boards of health and health units to become the MSAs.

Mr Wessinger: Yes, I think it's fairer to characterize the provisions as not prohibiting, but—

Mrs Caplan: Discriminating.

Mr Wessinger: I think that's fair, yes, giving a preference to non-profit organizations. Certainly, I think, one of the issues that has been raised by the board is quite accurate with respect to one of the considerations, and that is the governance model. I certainly was very interested to hear their suggestions that that could be changed.

I think the other aspect is that in the province of Ontario we've had a long tradition of providing our health services and our social services through the non-profit, voluntary model. If we look at our hospitals, if we look at our social services, that's been the major method by which we developed delivery of services through the province. Boards of health are deemed, I suppose, as governmental models, as distinct from the voluntary, non-profit model, and I would suggest that's a major reason for the preference for the agencies which have a volunteer, non-profit model.

Mrs Caplan: At the back of their presentation, they state what is in the Health Protection and Promotion Act which permits, without a change in legislation, the balance on the existing boards of health to be one less than the majority of consumer appointments, if you will. I'm going to use that one specifically because that's your MSA model, and I would argue that the MSA model is almost possible without any amendments to the legislation. There are some boards already in the province that reflect that balance—not many, but there are some—and

it is certainly possible for that to happen under the existing legislation.

Secondly, it would be a minor change in the legislation that I think would be supported by both the boards and the units to that kind of model. The notion that the boards are governmental versus community, I think, is an insult to the boards and to the health units, because while they have dual accountability back to the local councils as well as to the Ministry of Health, from the fact that they are receiving funding from both for their program delivery, in many ways, from my experience as a former member of a board of health—actually, I used to joke and say that I had difficulty in becoming chairman of our local board of health; there were some local politics going on, so instead I decided I'd like to be Minister of Health.

The Vice-Chair: We'll excuse the comment. Proceed.

Mrs Caplan: I just make that as an aside to let you know of my long-standing history as a former member of a board of health. I do think that if the concern of the government is only the governance issue, then that could be accommodated by some minor changes, and that boards of health and health units should be considered, because I think the expertise is there already. The points that are made in this presentation are excellent and would be mirrored by numerous other boards and units across the province. So I'd like you to consider that.

The last question that I have really is of Dr Pollett, and that is, why did you leave North York?

Mrs Cunningham: Welcome to London. There's no answer.

The Vice-Chair: Realizing there could be several answers, we'll proceed. Did you want to comment briefly, or we'll move on. I've been asked by Mr Winninger for the opportunity to ask a very short question, I understand.

Mr Winninger: Yes. Actually, it's a comment because my line of questioning, as it transpires, was similar to Ms Caplan's. But I don't read that subsection 11(3) quite as narrowly as you do, and I don't think in any way it spells out a preference for an agency other than a district health council.

Mrs Caplan: Oh, it does.

Mr Winninger: It seems to me that if there were community consensus and the board could be reconstituted in a manner that matches the requirements of the MSA, there's nothing in that section that says that the minister shall actually choose another agency before you. It says that the minister shall consider the suitability of all other agencies, but it doesn't draw any conclusions in that respect. I think we have to be very careful to say that there might be a preference there, although the parliamentary assistant seems a little agitated—

Mr Wessinger: No, no.

Mrs Caplan: Well, it does discriminate against boards of health.

Mr Wessinger: I would just like to confirm that I would agree with Mr Winninger's interpretation that if your long-term care committee makes that proposal and has taken everything into consideration, certainly there's no prohibition, so I think it's still open.

Mrs Cunningham: So we can clarify it with an amendment.

Mrs Caplan: If I could just clarify it, because that was my line of questioning, am I hearing from the parliamentary assistant that it is the policy of the government not to discriminate against boards of health and health units in the determination and designation of MSAs?

Mr Wessinger: I think it's fair to say it's the government's position there's a preference for a non-profit agency, but I don't think there's anything in the process that prohibits a board of health from trying to reconstitute itself—I don't know what is possible—to fall into the category of a non-profit, charitable—

1550

Mrs Caplan: But the problem is that as the legislation is written and there is a clear preference—that is the word you use—and discrimination against boards of health. You have a preference for other than boards of health and I'm saying there's a discrimination against boards of health. Unless you're prepared to clarify the legislation, then in fact those community organizations, groups, committees of the DHCs and so forth will read this legislation and say, "We really have an obligation to give everybody else preference."

I think that if your policy is as you're stating, and that if it—with some governance changes that you would have no problem. I would hope the government would bring forward an amendment to this legislation that would clarify that because, as it stands right now, you're discriminating against boards of health.

Mrs Cunningham: We're putting forth an amendment in that regard.

The Vice-Chair: Thank you. Any further comment by the—

Mrs Cunningham: Mr Wessinger agrees with it and so does Mr. Winninger.

The Vice-Chair: Please.

Interjections.

The Vice-Chair: Thank you for bringing further discussion before the committee. We appreciate that. You're all most happy I see, so any final comment? Then we'll let you go.

Dr Pollett: We simply want the opportunity to compete on an equal footing.

The Vice-Chair: Thank you very much for your presentation. We note that.

KENT COUNTY DISTRICT HEALTH COUNCIL

The Vice-Chair: The next presentation will be made on behalf of the Kent County District Health Council by several representatives.

Mr Bruce McCallum: I would like to introduce the group appearing before you at this time. My name is Bruce McCallum. I'm chair of the long-term care steering committee and a member of the Kent County District Health Council. I have with me another member of the district health council, Mrs Mary Lee—and it shouldn't be too difficult to determine which one is Mrs Lee—as well as Mr Paul Balkwill, who is a member of the long-

term care steering committee and chair of the MSA committee, and Mr John Ferguson, who keeps us all honest; he is Joe Consumer.

The Kent County District Health Council supports and applauds the efforts of the current government to make the necessary legislative changes which will enable long-term care planning committees to move forward in the implementation of long-term care reform. Bill 173 will provide the legislative framework required in order to implement proposed changes to the current system of long-term care services. Consumers of long-term care services will soon find themselves accessing a well coordinated range of health and home support system of services.

The new system of long-term care services will reflect many of the suggestions and changes that consumers have proposed over the last several years. On behalf of the long-term care steering committee of the Kent County District Health Council, I would like to thank the standing committee for their efforts to date and for the opportunity to present our response to Bill 173 today.

The Kent County District Health Council participated in the preparation of two responses to Bill 173. Both of these responses will be presented this afternoon to the standing committee on social development.

The first of these responses is a submission from the District Health Councils of Southwestern Ontario which will be presented later this afternoon, I believe at 4:30. As a member of the District Health Councils of Southwestern Ontario, the Kent County District Health Council supports the submission of this conjoint response to Bill 173. This response addresses the proposed amendments to the Ministry of Health Act. The proposed amendments will have implications for the role of district health councils in long-term care planning.

The Kent County District Health Council also supports the following submission by the long-term care steering committee that's appearing before you now.

This long-term care steering committee assigned a special work group to review Bill 173 and to prepare a report for presentation to the standing committee on social development here in London today. The Bill 173 work group consisted of five volunteers and one staff member, and the long-term care steering committee acknowledges the efforts of this committee to collaborate on this important task. The following report summarizes the results of the work group's efforts.

We've taken Bill 173, which I'm sure all of you must know by heart by now, and we'll just comment very briefly on these items.

Part I: Generally, the purposes of the act support the policy directions of long-term care and the local planning process to date.

Clarification is needed in terms of how health and social services will be integrated. Does the term "community services" used in clause 1(a) include both health and social services?

Further definition of "people," as described in clause 1(a), as the target population is suggested. For example, who does this include or exclude? The links to other

populations, such as the developmentally handicapped or those with a mental illness, are not clear.

Acute care as a component of long-term care is not clearly identified or addressed in the document.

Part II: It is suggested that meal cleanup be added to the list of homemaking services in subsection 2(5). It is also suggested that in subsection 6(2), "personal activities of living" be reworded as "personal activities of daily living."

Part III: Generally, the concept of the consumer bill of rights is supported. Under the act, the right to appeal will be clear to the consumer.

Part IV: In subsection 4(1), the position of director needs to be clarified. Despite the definition provided in subsection 2(1), it still is unclear what department or agency the director will be responsible for.

Part V: In clause 7(1)(b) and subclause 44(1)(c)(vi), concern is appropriately expressed for the health, safety and wellbeing of the person receiving services. Should the same concern not also be extended to the workers providing these services?

Part VI: This section supports some flexibility in providing optional services. This may allow local planning bodies to recommend services which are tailored to meet the unique needs of their local communities and to complement existing resources. However, it is unclear what resources will be allocated to these optional services, given that most of the funding envelope will cover the costs of the mandatory basket of services.

In section 13, the 20% limit on purchase of service is clearly outlined. However, another ministry document stated, "The purchase of services from commercial agencies will be limited to a maximum of 10% of MSAs' homemaking and professional services budgets." This statement appeared in the Implementation Questions and Answers dated June 6, 1994. If this is true, should this guideline not be included in the act?

1600

In clause 13(3)(c), the act describes the purchase of service from an individual. How does this individual qualify for an exemption from the 20% limit on purchase of service? The direction that the members of the agency's board of directors reflect the community on the basis of gender, age, disability, place of residence, as well as cultural, ethnic, linguistic and spiritual factors, may make the democratic process of selection impossible.

The long-term care steering committee is concerned that the validity of an agency could be continuously open to challenge based on a perception of the failure to comply with any one of the factors outlined in article 2(a) of the act. The committee recognizes by policy direction that an MSA board would be elected by its membership, but this is not supported by inclusion in the act.

In part VII, the committee feels that quality management referred to in section 24 should be designed by local MSAs.

Accreditation is not mentioned in the act. The committee feels the concept of accreditation needs to be included in the legislation of Bill 173.

Part VIII: The committee supports the act of participation of the consumer in the development of the plan of service.

Part IX: Who is the appeal board as defined in the act? Is this board in existence or is it a proposed board and, if so, who recommends membership on this appeal board?

Part X: Does subsection 50(4), obligate a service provider to provide care to someone who is not eligible for services? Could this subsection obligate a service provider to provide care for someone who is not eligible for service under the act?

Part XI: Section 56 addresses the role of the Lieutenant Governor in prescribing additional services. What is the role of the district health council in making recommendations on increasing service levels? For instance, can an agency apply directly to the ministry, or will the district health council consider this increase within the context of the broader picture of planning an integrated system of long-term care services?

The same line of questioning can be applied to paragraph 56(1)9 in terms of the role of the district health council in making recommendations on the allocation and reallocation of funds.

Paragraph 56(1)22 addresses the collection of information. Some of this information is essential to the planning process. What provisions in the act allow for the sharing of information between long-term care area offices and the district health councils, in order to allow for planning which is based on reliable and accurate data? Presently there is a duplication of the collection of information by government agencies and planning bodies due to restrictions based on confidentiality.

Part XII, subsection 61(1), addresses the role of the district health councils in planning. If district health councils are to make recommendations on the allocation of resources, they need to have access to information on financial resources in order to do so. The act does not address the accessibility of these resources in order to meet the mandate as indicated. There is some indication that the district health council and members of the public should have access to information relating to the present activities of the service provider and the future direction of the provider. The long-term care steering committee respectfully asks the standing committee on social development to carefully consider the suggestions in this report when making amendments to Bill 173.

I think the feeling is this bill is about care of consumers in their home, based on what the community determines as its needs within a framework of government funding and supplementary volunteers and local funding.

Could the bill be more consumer-friendly? It's a word we hear in communication these days and this group of consumers, or about to be consumers, some of us—I'll let you draw your own conclusions there—we realize that bills have to be made in an appropriate way, but communication's changed a lot since this format was first devised, I'm sure, and it would certainly assist planning bodies such as the long-term care steering committee to have it in plain, understandable English, the same as

insurance companies did with insurance policies a few years back.

That, ladies and gentlemen, is our report and I'd be most happy to refer questions to my colleagues.

The Vice-Chair: Thank you very much for your presentation and I note that there are a number of very important serious questions that you may or may not expect responses and answers to today, immediately.

Before calling on the parliamentary assistant to respond in what way and what time frame he can answer these various questions, I would ask Ms Cunningham if she has a question at this time first.

Mrs Cunningham: First of all I'd like to thank the group for your work because you've given, I think, a lot of thought to this presentation on a lot of specifics. I think, Mr Chairman, with respect, that any answers the parliamentary assistant could come up with today would perhaps not be very helpful, because you've asked so many questions and maybe what you'd like to have is some kind of a response to your brief in writing. I make that suggestion because I myself would like to see the answers to the questions; they are very well-thought-out. So, Mr McCallum, I hope you'll get a response in writing to your questions.

Earlier today we heard from a number of consumers but specifically, I think, this afternoon as we listened to Mr Balcom of the Independent Living Centre—he was a consumer and he used the same concern that you have, this user-friendliness.

Can I ask a question with regard to perhaps your own area—you can give us an idea—how do you think the ministry will be able to choose in your area, given the work that you've done, a multiservice agency? Do you, as a district health council now, think you have a group or an agency that could respond to this request?

Mr McCallum: Yes, I would like to refer that question to the chair of our multiservice agencies subcommittee, who has been working on it diligently for the past year. I'll let him take the—it's going to be presented to the public and the community for further discussion very shortly. Paul?

Mr Paul Balkwill: Thank you, Bruce. To Mrs Cunningham, Mr Chairman, our multiservice agencies subcommittee has put forward a design for a community health and support services agency. We've changed the name already to the long-term care steering committee and we believe that over the four-year period we've been given we can work through a transitional model to a full-blown multiservice agency.

There is a real concern that we have as a subcommittee group, and it is the issue of governance and it's been mentioned several times here today while we've been sitting here. If you accept that all of those areas mentioned in the bill must be reflected in the governance model, then the question is how big a board is this? This was put directly to me and I said, "I think that maybe a minimum would be 12, but probably you'd have to extend it to 20." Then, in fact, to be able to get the representation the bill suggests should be there gets the question of whether it can in fact be a democratic

process. I put that to you because if you're dealing with a county, for instance, and you must have geographic representation and then you must have spiritual and linguistic and all those other representations, and then to expect that it will be a truly democratic process—I don't know. We're really struggling with that and if the government can help us out in terms of how you'd go through that process to get a truly representative, truly democratically selected body, we'd really be interested.

Mrs Cunningham: I thank you for that response, because there are certainly other areas of government right now that are spending more time and more energy, and you know how important it is if we're talking about taking care of people here. That's where our energy should be, in making up their boards. For instance, in community colleges right now, the boards are spending all of their time fighting with the government as to who they can have on their own local community college boards. I don't want this to happen in this regard—not that I even like the concept, that's why I was asking you. By example, the previous presenters felt they were excluded, and yet they may be the best agency.

I thank you, and I hope we'll be free to talk in the future if we get into some difficulties during the drafting of the amendments with regard to this issue that you brought forward today, along with the others.

1610

The Vice-Chair: Parliamentary assistant, please.

Mr Wessenger: I think the best way is to write back to answer some of the questions you've asked. With respect to the whole question of board composition, though, I think it's fair to say that there's not going to be a prescription laid down that every group has to be represented. I think the minimum requirement is going to be that there's going to have to be consumer representation on the board, and the way most voluntary organizations work, through their nominating committee process they try to ensure that the people nominated for the board reflect the diversity of the community, but sometimes that doesn't work out, and that's understood that sometimes that doesn't work out. But that's the way it would be anticipated to be done, not a rigid requirement or prescription and bylaws that every group is represented. There would be a prescription certainly with respect to ensuring that a third of the membership would be consumers, but as far as I can see, that's about the only prescription that would specifically be there.

The Vice-Chair: So the ministry will be forwarding answers to your questions and circulating it to the members of the committee for information.

Mr McCallum: If I might ask a question of the Chair, if we have any time left, we have a question raised by one of our members here. If we have any time left, with permission of the Chair, I would like her to ask that question.

The Vice-Chair: Proceed, please.

Mrs Mary Lee: Thank you, Bruce. Thank you, Mr Chairman, ladies and gentlemen. I'm pleased that you've given me the opportunity to speak. I am a city council appointee to the district health council to the long-term

care committee to the MSA, as was requested, and I represent them today, not city council.

However, I brought up the fact that there is a bill called 173 to my city council last week. Not one of them had a clue that it even existed. I referred it to the administration and to the social work department and I guess the clerk's department to have them review it and come up with some recommendations or critiques or something. However, I discovered at that time it was a little late for the city council to make a submission. I think the deadline is we may put in our submission in writing by September 14.

Further to that, I've just returned from attending the AMO meeting in Toronto, and I felt personally that was one of the biggest things on the horizon right now for this coming three years. It wasn't even mentioned. I asked about it, and they said, "Well, maybe there is a committee at AMO doing a study on it." "But," I said, "did you realize you have to get your submissions in by September 14?"

The Vice-Chair: Actually, the Association of Municipalities of Ontario made a presentation to the committee. I believe it was yesterday morning. We can get a copy of that for you if you'd like to have it.

Mrs Lee: I feel very happy that they have done that.

The Vice-Chair: Then you could go through it and write regarding that if you wish to. But we will get you a copy of that if you'd like to have it.

Mrs Lee: Yes, but each municipality may still send in its submission, right?

The Vice-Chair: Yes.

Mr Wessenger: Of course, anybody can send in a submission.

Mrs Lee: Because our concern in our municipality is the funding. In the legislation it states it'll be funded, but it didn't say who or how much and when.

The Vice-Chair: The municipality, and I know it is a member of the association, should be getting a copy of the association's response, because that's the normal procedure, to send copies of responses on all matters to member municipalities.

Mrs Lee: Well, my other question was, then the city council should have received a copy of Bill 173, am I not correct? Do they not send this out to all city councils?

The Vice-Chair: Many municipalities do get copies of all—they apply and get the bills services of the provincial Legislature, which would ensure them copies of all bills as they come forward. But I don't think they would get it automatically if they're not a member of the bills services of the Legislature. So it is available, if you wish it, through that system.

The other thing is that of course the committee did advertise. The clerk of the committee did advertise the hearings, inviting representations, and that I believe is inserted in all daily newspapers, is it, across the province? So it would have been in the Chatham paper.

Mrs Lee: But because of the funding fact, municipalities should be very much concerned.

The Vice-Chair: Yes, and the association did make,

as I understand it, a lengthy presentation, and we'll get you a copy of that if you would like.

Mrs Lee: Thank you. Now, I just have one other comment, and that is, I hope that you won't be recommending to close down too many beds, because I'm a health services professional. I've been at it for 25 years. I still look after a lot of seniors, and the seniors who are needing help now are needing more and more total care. It's practically impossible to send an 80-year-old semi-stroke home to be looked after on home care by an 80-year-old spouse. I just want you people to consider that before you make your vote.

I have even been brave enough to say that before people make these rules and regulations, each and every one of you should take one of these people home and look after them for a week before you come back and make the decision, because I'm very concerned that home care is not the be-all, the answer to everything, and it is not better care than some institutional care that's going to be needed, because one of the things is, big people are big, and in the hospital you can get two or three people to help you lift, turn and change them, whereas at home you're the only person and it's nearly impossible. Thank you very much for giving me this opportunity.

The Vice-Chair: A very serious concern; thank you for expressing it. Thank you for your presentation.

Mrs O'Neill: Mr Chairman, as the next group comes forward, I'm going to repeat now for the third time my request. This group brought it forward and other groups have brought it forward today. I think we have to clarify the implementation of the capping.

Now, we're being told that there's going to be an answer to this brief and we're going to be given a copy of it. I'm sorry; I'm not willing to wait for that. I feel now that the question of the appeal board and its membership has come up several times, and several times today. I'm making a further request now that we know who is going to make up the appeal board and I think this committee should get that information very soon.

The Vice-Chair: Could we just table that for the present time? The next presenter has a very serious problem with meeting a transportation deadline, as I understand.

PERSONS UNITED FOR SELF-HELP SOUTHWESTERN REGION

The Vice-Chair: The next presentation is made by the representative of Persons United for Self-Help Southwestern Region. Please introduce yourself and proceed.

Ms Myrtle Evans: I'm Myrtle Evans, by the way, and I am vice-chair for Persons United for Self-Help. Now, I must admit I've learned a good deal today.

Persons United for Self-Help Southwestern Region—we call ourselves PUSH, by the way—have been consistently present at discussions surrounding long-term care. We have come to the table every time LTC—which is long-term care, I understand—has been raised. We stay involved at all levels of discussion because we believe that adults with disabilities have historically been insulted, then omitted, overlooked or ignored in governmental action planning. We are determined to ensure that

long-term care, in this case Bill 173, will genuinely address our issues and concerns.

It is unfortunate that this Long-Term Care Act, 1994, Bill 173, has slipped so easily back into the errant ways we believed had changed. However, until such change becomes truly evident, our support for these initiatives will be withheld. Adults with disabilities have a reason to be concerned when they see years of working with government set aside on marginal input, but that is what Bill 173 has done.

Definitions: The absence of a definition of an individual within the bill says more about its intent than do all the other words strung together. This is particularly relevant in light of the recent announcement of the district funding program. The district funding program, one accommodating the individual, will not be functional without the appropriate wording included within the act.

We recommend the inclusion of the following definitions:

—Individual: one person, one specific set of circumstances, personalized;

—Direct funding: program supplying attendant service dollars to an individual to coordinate, account for and report on their own service.

As for the bill of rights, we respect this initial step in addressing the concerns of service users within the support service system. However, there are inconsistencies in the document which displace the intent of these rights. Examples of the problems herein lie in:

(a) The qualifications for being approved agencies, district health councils, committee of chairs, multiservice agencies, review boards or others. Nowhere is representation by consumers mentioned. The criteria cited call for "...persons experienced in the health services field..." This clearly prohibits participation by most disabled consumers.

(b) The fact that an MSA must meet four service delivery criteria. These are community support, home-making, personal support and professional.

1620

(c) Ratios of membership for cited categories have been omitted as well.

(d) There is no longer an acknowledgement of the value of consumer representation and participation at this level. Only those who profit from their systems' enrichment are included.

Accountability: Once appointed, by the minister or each other, the approved agencies, district health councils, committee of chairs, multiservice agencies, review boards and others are accountable to only the minister or each other. There are no provisions for being answerable to the geographic area. The local representation promised long ago is no longer evident.

Bill 173 then proceeds to renounce ministry, approved agency and service provider responsibilities for any future problems or injuries by stating that consumers must accept that providers are acting "with good intent." This is a prime example of governance in full abdication. It is an open-eyed endorsement of irresponsibility and

omission. In the access to information criteria, consumers could be denied access to their medical records by service providers. This denial can be appealed to the Consent and Capacity Review Board, which may or may not uphold the original denial. This clearly violates an individual's human rights. Further, should the service provider present a medical affidavit stating the complainant is medically incapable of attending the review, the affidavit will be accepted at face value.

This provision is paternalistic. At no time should the consumer be absent from such reviews. Indeed, we charge the minister with the responsibility of establishing an extraordinary-measures clause which would necessitate a review postponement until the consumer is able to participate, or to go one step further and provide the required support to permit the consumer to participate. Should the denial-of-access decision be reversed, the consumer should then be provided the full information in the format they utilize best. I presume that's Braille, loop system or whatever you want.

Another unreasonable expectation is that unregulated waiting lists are still being endorsed as a method of addressing limited service availability. There is no purpose for approved agencies to assess client—consumer—requirements or assess eligibility for service when there are no services available for the consumer. This service screening formula is predicated on the nuance of a needs-based assignment, yet in reality assessments work from the least-needful-get-service criterion. The incompatibility of the two methods results in consumer mistrust and frustration with the waiting list juggling act, which will not be dissipated with Bill 173.

Appeal avenues: It should be noted that ultimately ineligibility, non-availability, limitations or termination of service may be appealed to the Health Services Appeal Board. Yet there are no preliminary steps established to provide a more expeditious remedy. Further, the Health Services Appeal Board is already experiencing a minimum of a one-year backlog of complaints and will not provide a reasonable remedy for consumers who are in desperate need now.

Quality assurance: It used to take a simple telephone call to MCSS to resolve the glitches we experienced with attendant service. Then we were shifted to a long-term care area office and Gail Ure answered our questions. Now we're in a befuddled mess, with no one who will identifiably understand our services or be capable of responding to us.

We know this is not quality assurance, but we don't know what is. We cannot find a person in the milieu who is accountable for our concerns. We would like to know, what are the quality assurance standards, who is responsible for them and what are the evaluative techniques and implications?

These absences of consumer representation and choice, as well as the absence of accountability, appeal avenues and quality assurance guidelines discussed in the legislation raise more questions when one considers that we will be captive to the long-term care system.

Conclusion: Consumers are now raising more long-time—the tongue's all right; the head's got to go—long-

term care questions than ever before. Their concerns are based upon the fickleness of a government that cannot decide whether adults with disabilities will be included in the hierarchy of decision-making or not. The multiple levels of systems bureaucracy outlined in Bill 173 indicate that disability-related services will be lost quickly in the morass.

Promises of participatory status for disabled persons has proven illusory. Application to Thames Valley District Health Council by PUSH Southwest members has been fruitless. Indeed, we have all been advised that we don't make the infamous short list for interview consideration. Ministry of Health promises do not match our reality.

Perhaps the time is right for the Ministry of Health to acknowledge its deficiencies, particularly with disability issues and programs. We recommend that long-term care services for the disabled be returned, with the appropriate dollar assignment, to the Ministry of Community and Social Services. Ministry of Community and Social Services offices have always been effectual and responsive to our needs.

Unlike hospitals, nursing homes, homes for the aged and other institutions, we are a small but specifically needful population. We require responsiveness that can no longer be found in Health's growing layers of "expert" bureaucracy. We must be allowed to return our basic services to the ministry which served our needs best, the Ministry of Community and Social Services.

The Chair: Thank you for your presentation. Do you have time for a question?

Ms Evans: A couple. I'm not sure I'll be able to do them. I'm going to call Steve if I need him.

Mr Malkowski: Thank you for your presentation. Just to make sure I understand you correctly before I ask for clarification from counsel, were you saying that what you would like within the legislation is a guarantee for consumers specifically that people with disabilities are involved in the decision-making process and that in fact diversity is recognized within the legislation? Is that what you're looking for?

Ms Evans: Yes. I really think what we have to have is, the consumer has got to be recognized and involved, because nobody understands a person's needs like that person themselves. It takes someone in a similar circumstance to even, shall we say, interpret what the other person maybe needs or wants, because we've got an awful lot of people who—in the last 10 years, personally I didn't understand a lot of people's needs, and I've been in a wheelchair for 40 years. But there are oodles of things I don't know anything about, because long-term care was not something I've ever used. I've been appalled at what they have been stuck with, their time schedules and a lot of things.

It's necessary, but I don't think people who are able-bodied understand that these people are so tied up. Like I am tied up right now because I've got to get a time schedule for my booking for Paratransit. Somebody else has got a time schedule; they've got to get Paratransit, they've got to get to support care, and if Paratransit's

late, support care isn't there. It's pretty rough on them.

I want to thank you. If there are any more, I'll take one more.

Mr Malkowski: If I can just ask counsel for clarification on the nomination process, one of the concerns was, for example, that people have not been able to get involved in the process although they have tried to get nominated. What exactly is the process and could you clarify that for us?

Mr Wessenger: I'll just ask the counsel to go ahead.

Ms Czukar: I'll just be quick, if I can. What the bill provides for is that the minister, when designating an MSA, must consider the proposed board composition. She has to consider whether the board of directors reflects the diversity of persons to be served, according to certain factors, and disability is certainly one of the factors, and the minister has committed herself to wanting to see at least a third of the board being consumers.

1630

The legislation doesn't use the word "consumers." What we have here, we believe, is a working definition of consumer, but if people want to see the word "consumer" there, maybe we can find a way to put it there and have that definition.

The other thing I would say is that the requirement with respect to a plan of service, participating in assessment and determination of need and that sort of thing in section 20, also requires the agency to give the person the opportunity to participate in developing the plan of service, plus they can name someone else to participate with them. So your point about sort of moral support in the process is a good one and is accommodated by that provision as well.

Ms Evans: I think that answers our questions.

The Vice-Chair: Thank you for the presentation.

ST JOSEPH'S HEALTH CENTRE, SARNIA

ST JOSEPH'S HEALTH CENTRE, LONDON

Mr Don McDermott: Mr Chairman and members of the social development committee, my name is Don McDermott. I'm the administrator of St Joseph's Health Centre in Sarnia. With me today is Mr Philip Hassen, president of St Joseph's Health Centre in London.

We are here to represent our institutions, to encourage reconsideration of certain areas of Bill 173. Thank you for this opportunity.

St Joseph's Health Centre, Sarnia, is an accredited 317-bed community-based Catholic health care facility owned and operated by St Joseph's Health Services Association of Sarnia Inc. St Joseph's offers a range of health services to the residents of Lambton county which encompass the pre-birth to death experiences. These family-oriented services and programs both complement the roles of other health care organizations in the county of Lambton and as well make their own contribution.

St Joseph's Health Centre, Sarnia, provides active treatment services in general medicine, intensive care and surgery. We also provide the specialized regional programs and services of obstetrics, long-term care, rehabilitation, palliation and sexual assault treatment. A variety

of urgent care needs are met in our emergency department, and through ambulatory care we provide outpatient diagnostic and treatment services. Specialty clinics and facilities complement our inpatient services and assist people to live independently in the community.

St Joseph's Health Centre, London, provides an unique continuum of care to the very young through to the most senior in the community, encompassing acute, residential, extended and long-term care services. An accredited Catholic teaching facility, it is affiliated with the University of Western Ontario and Fanshawe College. The health centre is owned and operated by St Joseph's Health Services Association of London, Inc, whose members of the corporation are certain Sisters of St Joseph.

The corporation consists of St Joseph's Hospital for acute care, St Mary's Hospital for chronic and rehabilitative care, Marian Villa for extended and residential care, the Lawson Research Institute and various programs located within the community.

The major program thrusts of the health centre include perinatology, gerontology, endocrinology and metabolism, gastroenterology surgery, hand and upper limb orthopaedic plastic services. Within gerontology, multidisciplinary programs include long-term care units and ambulatory consulting clinics. St Joseph's Health Centre is a partner in the regional geriatric program, which includes an acute assessment unit and outreach teams. The health centre is a partner in the Centre for Activity and Ageing, in a cooperative venture with the University of Western Ontario.

As a provider of hospital-based health services in Lambton and Middlesex counties, as well as southwestern Ontario, we support the goals of long-term care reform and the purpose of this act as stated in part I of the legislation, and we are pleased to appear today on behalf of the boards of St Joseph's Health Centre, Sarnia and London.

We share the Ontario government's concerns for integration of long-term care health and social services, improved access, community-based care where possible, consumer participation, racial equity, cultural sensitivity and spiritual recognition, funding equity across the province and protecting our staff. We agree with our affiliative bodies, the Ontario Hospital Association and the Catholic Health Association of Ontario, who have voiced the need to simplify access and coordinate services within the long-term care sector.

Of concern, however, are the implications of this legislation that could decrease consumer choice if services are limited to only those offered through MSAs in a particular area; diminish voluntarism and fund-raising if MSAs are divorced from agencies currently providing care in the community; decrease involvement of hospitals in the continuum of health care and the potential displacement of staff who currently provide these services; and the appended district health council roles that appear out of place in this legislation.

Our presentation today is an attempt to give Bill 173 a positive impact on health services in Ontario, building existing systems and linkages of providers into a continu-

um of care. Our first concern is a lack of consumer choice. Consumers will have considerably less choice under MSAs than they do now and will have difficulty being accommodated with their first-choice placement. Indeed, a person may in fact wish placement within an institution for reasons such as the religious nature of the provider but be unable to have it because of the nature of the MSA. As described in part III, the bill of rights, paragraph 3(1)3, spiritual consideration must be a component of placement selection for services. This will be difficult to operationalize within this legislation.

There are many charitable non-profit providers, both religious and otherwise, who will not become part of an MSA because of the limitations the restructured MSA governing bodies would impose. Often these providers are of a specific spiritual or cultural mission. Elimination of these choices, as would occur under the proposed Bill 173, would not allow the consumer the choice of cultural sensitivity or spiritual considerations as described in the bill of rights or as is currently available.

The identity of many organizations will be lost, but even more importantly, established standards, efficient operations and functional teams of health professionals trusted by the community as representing certain values will disappear.

We therefore recommend that the spiritual consideration, as a consumer choice of services provided by MSAs, not be lost in the effectiveness of the legislation.

Our second concern has to do with the loss of identity and its consequences. The perception of an MSA is one of government bureaucracy in consolidating the services of current provider agencies. People give to agencies to which they feel ownership, affiliation or need. A government agency will not have an identity to which people will give either time or money.

The potential loss of culture and history should not be ignored as this bill proceeds. Surely a current provider can be incorporated into an MSA through affiliation rather than absorption. The opportunity for multiple MSAs in one region is present in the bill, part VI, subsection 2(4). This affiliation would strengthen the voluntarism and potential fund-raising capabilities of an MSA while building on the identity and expertise of current providers.

1640

The opportunity for affiliation should be explored before legislating absorption of agencies which provide value-added programs through their diverse and independent governance structures, religious affiliation and quality programming.

We therefore recommend that planning for MSAs in each area include the opportunity for affiliation agreements and multiple MSAs, rather than limiting models to absorption of existing agencies within one MSA.

Our third concern is decreased recognition of institutions as part of the continuum and the potential displacement of current service staff. Many institutions currently provide services to clients in their home and in a group setting. The 20% maximum cap on MSAs' purchased services will eliminate many current providers and

potentially shift the service to an MSA without shifting the care giver.

Existing expertise and provider-consumer relationships should be maintained and built upon wherever possible, with special recognition given to ensuring the 20% purchase cap does not displace health workers who already provide this care. The 20% maximum for purchased services seems arbitrary and should be left to the individual region for the right combination of provided and purchased services, be they for-profit or non-profit.

Should it be determined that a service is best provided by staff of an MSA rather than a purchased service, the staff of the current provider should be given the opportunity to relocate to the MSA before the MSA hires another staff person. This will prevent significant displacement of workers across the province.

Institutions can play a leadership role in this human resource planning and transition if the other players are willing. In ensuring that a wide range of community-based services are available in the home as an alternative to institutions, the legislation fails to understand the valuable role institutions currently play in adult day programs, specialty clinics, information resources, training, professional and support services, palliative care and respite care. Institutions should not be considered an alternative to community care, but rather a partner in a continuum of care that will see clients using various institutional and community-based services at different times as their needs require.

MSAs should be structured to ensure that this partnership with institutions continues in community service provision and planning in an efficient and economic manner, through single access.

We therefore recommend, first, that the 20% maximum on purchased services be removed and that each region plan its own ways of providing efficient and effective services through its MSA model; second, that a human resources plan for MSAs give consideration to all existing providers for staffing needs before new hiring takes place, and institutions need to be a player in formulating this plan; third, institutions be considered and included as full partners in a continuum of health care and not seen as alternatives to community-based care.

Our fourth concern has to do with district health councils. The inclusion of amendments to the Ministry of Health Act in subsection 62(1) to enshrine district health councils' governance and functions deserves special legislation rather than what appears to be a disjointed or last-minute approach by adding their role to a long-term care bill.

This process is doubly confusing in that the Lawson report, the final report of the regional planning steering committee for southwestern Ontario, tabled June 1994, appears to recommend another layer of planning bureaucracy above the district health councils, with similar duties but without stakeholder consultation. These regional health councils need review before district health councils' roles are enshrined in legislation so that everyone's responsibilities are clear.

We therefore recommend that district health councils

be given individual legislation that is well thought out and clear in its relationship to regional health councils, as defined in the Lawson report, and the Ministry of Health.

In summary, we are pleased that action is being taken to lead a process of integration and improved access to the long-term care health and social service areas. We question the legislation in reducing the consideration of choice, especially of a cultural and spiritual nature; the use of absorption rather than affiliation tactics; limiting MSA purchased-service options, and we reinforce the need to consider a human resources plan. We also request that health institutions be seen as partners in this process, and we question the reason for district health council legislation in this act.

Thank you for the opportunity to present before this committee.

Mrs Caplan: Thank you for an excellent presentation. The question that I have relates to the areas that you've selected. We've heard a lot about the consumer choice, so I'm not going to question you further on that because I think that's clear. But what I am interested in is your view of the ability to purchase services above the 20% maximum that this legislation allows.

I'll start out by saying that I share the concern that you have, but I'm interested in what your experience has been as an institution that's looking at efficient ways of delivering service and whether you know of other institutions that are outsourcing services and whether they have had any experience around cost-savings as they relate to purchase of service from the private sector? Do you know what the institutional experience is?

Mr McDermott: We provide a number of outpatient services and in-community services through various agencies. Often this is done because some of the professionals are located within our institution and are often not available to the community agencies in any other way. Of real concern to us is that, should the MSAs be structured as within this legislation, first of all, institutions would then be separated from the MSA process. Second, the professionals who work for us would not have an opportunity necessarily to become part of that MSA process. Both of those are failings of this legislation and don't take into account the opportunity for the professional or the institution to be part of the process.

Mrs Caplan: Do you feel that could be accomplished simply by the elimination of the 20% maximum? Would that ease your concern about that, or do you feel there's another part of the legislation that would require amendment to ensure the continuum and the partnership between the institutional and the community-based care requirements of the patient or client?

Mr McDermott: I'll answer the first part. The 20% is limiting, I think. It really limits the opportunity to negotiate and to work together within a region or community. The second part, I think that institutions are not really addressed within this legislation, and if you look at acute care reform across the province, really excellent things are happening within institutions and among institutions. I think there's opportunity within community agencies to do very similar, positive rather than negative voluntary activity.

Mrs Caplan: I like the language that you used on page 7 when you say that each region should be permitted to "plan its own ways of providing for efficient and effective services through the MSA model," and I'm aware of the concern that you have about the mandate given to the DHCs. Where do you see that regional planning taking place?

Mr Phil Hassen: Maybe I can just add a couple of points to those that Don has already addressed. I do think that we need regional planning. There's no question as we go through these transitions, and there needs to be though a final source of decision-making on some of the issues. The problem is that they never seem to get done at the level they need to be done. They seem to keep wandering through, up the government levels. I won't belabour it, but we just had a document we needed to get done—and, Mrs Caplan, I think you remember the St Mary's project. We are now getting the tunnel and it took 13 signatures to get that done, just to get a little piece done.

Our question is, who's deciding these things and what are the objectives that you have in health care reform? It seems to us a systems approach needs to be taken in an integrated way within communities, not in what are seemingly traditional stove-pipe agendas to protect certain turfs, whether it's hospitals or whether it's communities or whether it's district health councils. The integration has to occur and it must occur at the local level.

The question that needs to be answered is whether you're prepared to let the local communities, with some parameters and final decision-making, make it happen. I think there will be some differences, but there can still be policies explicit by government to guide that.

1650

Mrs Caplan: That's why my question is—I don't want to use any specific term. What table do you see that happening at? I'm familiar with the fact that there are a number of proposed alternatives for this particular area, but if it's not the DHC, and you're concerned about a regional DHC, and it can't be the hospitals by themselves, where do you suggest that regional planning take place?

Mr Hassen: I wouldn't exclude the DHCs, but I think they need to be reformatting. For example, for London, because of the complexity of its serving southwestern Ontario, there needs to be a body that incorporates the needs of those people and the sensitivities to it, and thus legislation must contemplate those requirements. It cannot be done, again, just for London.

While I think London's DHC has been very sensitive to that issue, there are still issues arising that go beyond and the complexity of planning is so large, I think it needs a table that is of that nature. But I do think you need one kind of body that says, "We will make the final decisions on these things at our level." It doesn't have to go to government if it's within the mandate of the parameters established by government, or the policies, but unfortunately the policies never seem to be quite clear. I think we need to clarify those so that people at the local level can make those decisions.

The Chair: Thank you both. I know we could continue this, but I regret again time is our enemy. Thank you for coming and for your presentation.

DISTRICT HEALTH COUNCILS OF
SOUTHWESTERN ONTARIO

THAMES VALLEY DISTRICT HEALTH COUNCIL

The Chair: If I could then call the Thames Valley District Health Council and long-term care planning committee. Members will note there are two presentations—how I can put it?—two presentations with this submission. Does that cover it?

Ms Kathryn Bamford: Yes, that's correct, actually.

The Chair: Okay. I think I'm in your hands. If you would like to present both of them, that might be the best way and then we'd move to the questions, but we thank you. We recognize a few faces but recognize as well that people play a variety of different roles. Welcome to the committee and please go ahead.

Ms Bamford: Thank you very much. I was going to say my sister was here this morning, but you've obviously taken the wind out of my sail, so to speak.

First, I'd like to present not only for the Thames Valley District Health Council, of which I'm chair, but also for the District Health Councils of Southwestern Ontario. We've gotten together and put together a collaborative presentation. That will be the first part of our presentation.

The second part will be specific to our long-term care committee of the Thames Valley District Health Council. I'll briefly go over some of the points that are in the presentation there as well.

As you know from this morning, my name is Kathryn Bamford and I'm a three-year volunteer with the district health council. I'm past chair of the long-term care committee and present chair of council. I'm also past chair of the Oxford Senior Services Advisory Council and the executive director of VON Oxford. I'm a Woodstock resident. I'm a consumer and a mother of two teenagers.

The Chair: Many hats.

Ms Bamford: Many, many hats, so you're hearing this from many perspectives. I suppose I became extremely interested in district health councils from all those various perspectives and trying to find answers, to find out why and what can be done about the system the way it is now.

The District Health Councils of Southwestern Ontario value the opportunity to respond to Bill 173. This response will focus on the act's reference specifically to the district health councils. Additionally, the six health councils within the southwest planning region have prepared individual responses specific to long-term care contained in Bill 173.

I'll just talk a little bit about district health councils for those people who are unfamiliar with the concept. We were created in 1973 under the Ministry of Health Act, which stated that, "The Lieutenant Governor in Council or the minister may appoint committees to perform special advisory functions as are considered necessary or desirable in order to assist the minister in the discharge of his or her duties," and, "Subject to the approval of the

Lieutenant Governor in Council, the minister may make regulations...requiring and providing for the approval by the minister of regional and district councils for planning health and hospital services and their structure, functions and duties."

In the southwest region, six district health councils are established by order in council, including the Essex District Health Council, Grey-Bruce, Kent county, Lambton, Thames Valley and, most recently, Huron-Perth.

Additionally, the five health councils existing in the southwest in 1990 established an informal structure called the District Health Councils of Southwestern Ontario, the reason being to collaboratively address cross-district health planning issues. In 1993, the Huron-Perth steering committee, before it had a DHC, joined this body and started to collaborate with us on different issues.

All members, such as myself, of the district health council, excepting the staff, are volunteers and volunteer their time regularly and frequently to plan system responses to the community health needs. We see our purpose as trying to integrate the different aspects of our planning committees. These members are pleased that after a 20-year history of providing the citizens of their districts and the government with valuable health care planning advice, the government is now prepared to formally recognize our important work through this proposed legislation. This not only provides recognition but, also importantly, conveys the credibility and legitimacy of our role to the health care provider and consumer communities.

I'll just talk a little bit about the amendments, and it's really contained to pages 47 and 48 of the act, where we talk about the specifics to the district health council. We've added comments in addition to what the act outlays.

Councils suggest that subsection 8.1(1), which refers to areas not included in the DHC and the geography, may be redundant since now all geographic areas of the province and all non-aboriginal populations are represented by district health councils following the establishment of the Huron-Perth District Health Council.

With subsection 8.1(2), regarding members, the councils agree with the role of the Lieutenant Governor in Council or the minister in appointing council members. Councils do, however, stress the need for the appointment process to proceed in a timely manner.

At present, we have five openings, for instance, in the Thames Valley District Health Council and nominations have gone forward. But we may operate for almost six months without those five members, which leaves the rest of us having to really do double duties, so it really does burden the members who are presently there. We would ask that this process be improved.

In subsection 8.1(3), again councils agree with the role of the Lieutenant Governor in Council or the minister in ensuring that the membership of the district health council reflects the diversity of the population in the council's geographic area. Notwithstanding the above, councils stress that appointments be made based on skills and experience and not on any particular group represen-

tation other than gender or geographic, since at no time is it possible for a council to have all interested groups represented on this membership.

You may very well be aware of two position papers which have been presented to the ministry, one regarding a labour issue and one regarding OMA and wanting representation on health councils. I think it needs to be emphasized that their input is extremely valuable and can be acquired through professional bodies or other affiliated organizations, but to have actual representation specific to that group is very difficult to deal with at the council table.

Clause 8.1(4)(a), regarding functions: Councils agree with the stated function of advising the minister on health needs and other health matters in the council's geographic area but stress that in doing so, councils are responding to both the policies of the ministry and the uniqueness of their local districts and communities. I think we feel very much a dual accountability, both with the ministry's policies and directions as well as the communities in which we live.

Clause 8.1(5)(a): Councils accept the right of the minister to direct them not to exercise one or more of their functions with respect to the aboriginal community, but ask that the proposed legislation be revised to ensure that any health care planning conducted by aboriginal groups is shared with the relevant health council, since the providers of health care for these populations are usually existing providers who serve other, non-aboriginal populations and that recommended changes to delivery of services must not be acted upon without the district health council's assessment of its impact on the district's broader health system. I think again this illustrates the point of how interdependent the system is and how important it is that we communicate with each other, because there tends to be a domino effect that we are in fact planning with the people in their best interests.

Subsection 8.1(6): This section is most relevant to the current policy of the ministry which requires all hospitals to submit yearly operating plans to the district health councils. Extending this role for district health councils, such that all health care providers are now required to submit these operating plans, must be considered within the context of the need for additional health resources for the councils to objectively and fairly review these plans in detail, deserving of the role. What we have seen this to be is an added responsibility which again assists us with this integration and congruence within the health care system. But again the problem is the strain of limited resources and the strain of limited volunteers to actually do the work.

1700

Clause 12(d): Councils agree that the role of the ministry vis-à-vis district health councils is to govern them, but the term "govern" is not consistent with the term "manner of operation." Councils expect to be able to interpret the ministry's governing policy within the context of the local need. If council, for example, believes that it doesn't require an executive committee, then it should not be required by the ministry. This type of micromanagement by the ministry can discourage

innovative thought by council members at a time when such creativity is needed. The governing role of the ministry should be one of stating ends and identifying means only to the point where any reasonable interpretation of those means by councils can be accepted by the ministry.

Clause 12(d.1): The stated role of the ministry in governing the recruitment and selection of members of committees, or of any class of committees, of a district health council is again interpreted by councils as possibly overstepping the intended bounds of governance. Committees are committees of councils, not committees of the ministry, and such are the council's means of achieving the ministry's ends. If the ministry controls this level of means, it again risks stifling creative approaches across the district health council system.

An example of that: We have presently seven committees of council. The long-term care committee has many, many subcommittees and we're totally engaging, on a regular basis, 212 volunteers—we just did a head count before I came—on that one subcommittee of council alone.

The six district health councils in southwestern Ontario are encouraged by the scope of Bill 173. The suggested revisions to the sections referring to the district health councils are represented by those with significant experience in serving their Minister of Health, the ministry and, most importantly, the communities and individuals within those communities. Hopefully, they will be reviewed in the constructive manner in which we presented them today and in which they are intended. Thank you.

I have Paul Huras, the executive director of the Thames Valley District Health Council, to help me with questions in this regard.

The Chair: Okay. Should we do the long-term care planning committee presentation as well and then we can question on both?

Ms Bamford: Sure. How much time do we have?

The Chair: We have time for you to do that and then for questions, because I know you will do it expeditiously.

Ms Bamford: I wasn't planning to read the whole thing, but maybe I can just speak to a few items.

I had the privilege of chairing this committee for two years and I'm now past chair. Marian Millman is the chair. With me is Judi Fisher, who's a member of that committee. We have three council members on that committee. There are 22 members and we wrestled with this whole issue of representation and interests to be somehow represented at the table and we worked through that. You'll see that there are some fairly significant suggestions and comments about the act, and I won't go through all of those.

I'd like to move on, if I could, to a couple of the issues that are of most import and one is item number 14. I didn't hear, this morning when I was here, how this was addressed. Item number 14, page 3, speaks to children's services and long-term care. I don't know if you're aware, but the ministry of Community and Social Services is now undergoing a restructuring exercise. I've just

received a fairly lengthy survey asking for input on what restructuring means and how all that happens.

I'm wondering where these children fall. Many of them fall between the cracks of the Ministry of Community and Social Services and the Ministry of Health, and again, the long-term care committee has put together its concerns, asking, where do these children fall in the act? Services to children who are medically fragile and who have high care needs and to their families who require nursing and therapy services should be included under the basket of mandatory core services. They need to be included. They tend to fall between the cracks. These are people who have had to label their children, so to speak, to fit the funding envelopes that have been available in the past. So this really needs to be addressed.

It's important that the core nursing and therapy services in the MSA provide nursing and therapy services to children, wherever they may be, including day nurseries. Right now, there is an exclusion in day nurseries that children are not able to get the service, which burdens parents tremendously. If we look at that whole continuum of care and keeping those families well to maintain those children throughout their life expectancy, through their lifespan, and give them some quality of life, then we need to care for those parents and care givers as well. We hope that if it's not the intention of the core programs to provide nursing and therapy services in day nurseries, it be reversed as soon as possible, as stated in the legislation.

The other thing I just wanted to reiterate, and it was spoken about this morning—a gentleman, a consumer, spoke to it—was the appeals process. The long-term care committee felt very strongly about this. They certainly agree with an appeals process but would like to see the following included in the regulations for the process. The process should be independent of the MSA and there should be local appeal boards, which make the decision, linked to the intended provincial board. It is important that these boards be located at the local level for expeditious response, and that reiterates what this gentleman said this morning.

The boards should be able to be put in place and respond quickly, and we suggest that the provincial and local appeals board comprise 50% consumers and 50% others, defined as non-ministry-funded agencies, member representatives of education, local businesses, local church groups, to ensure objectivity and an arm's-length approach. Those are really the two most salient points, I think, in this presentation.

The Chair: Fine. Thank you. Can I express my ignorance? You may have said this, but if not, I may be joined by other members at the table. The Thames Valley District Health Council then covers Middlesex—

Ms Bamford: Elgin.

The Chair: Oxford?

Ms Bamford: Oxford.

Mr Eddy: London and St Thomas.

Ms Bamford: Yes, London.

The Chair: Thank you. I knew one member of the committee would know all of that. Mr Eddy knows this.

Ms Bamford: Yes.

The Chair: Okay. Thank you. I just wanted to be clear on that. We thank you for both of those, and I know that a number of the other issues that are raised in the long-term care committee's presentations are ones certainly, that we've seen before, but we have them here on paper.

Mrs Cunningham: This is the second presentation today by a district health council, but obviously you've gotten together with regard to the first one, so that's great.

I noticed that underlining the concerns of, I guess, all three presentations, but especially the latter one and the one from Kent, was the appeal board. I'm underlining them as they appear. Also, you didn't talk about the cap, I don't think, the 20%—

Ms Bamford: No.

Mrs Cunningham: —and the problem in choice in that regard. I wondered what your opinion on that would be. Also, with regard to defining the individual, you talked about that, and I'm happy that you noted the representation of the consumer on these boards and then of course the makeup of the appeal board.

I wondered if you did want to talk about the cap, and also, as a number of district health councils, have all of you considered different agencies that may qualify within their own geographical area as the considered agency under the act, for the provision of the services?

Ms Bamford: Okay, so the first question you have, Dianne, is with respect to the capping, the 20%?

Mrs Cunningham: Yes, I'd like to know your opinion on the capping because it seems to come up everywhere.

Ms Bamford: It does seem to come up. I'm probably a bad one to ask that. I will pass this over to Judi Fisher, who is the member of the committee that also generated the discussion paper which you may have seen in January—not Judi alone. Certainly, there was a committee struck at the time I was chair of council that put together that discussion paper. Again, that's what it was, to generate discussion, and it was presented at a long-term care conference in January. I think I saw some of you there. It addressed, actually, our collective thoughts that certainly are representative of many of the consumers at the table of the long-term care committee. But I'll pass it to Judi to speak to, because it would be an update from that actual discussion paper.

Ms Judi Fisher: I should say thanks, eh?

Ms Bamford: Yes, right.

Ms Fisher: Actually, we did make a comment, on page 2 of our presentation, on the limits of service, but the reference is more in terms of the flexibility. Those were comments by some of the members of our committee who are home care managers, in terms of flexibility.

We didn't specifically make a comment on the cap but we still have some concerns on the limiting to the 20% purchase of service. I don't think we actually put that in our presentation.

Mrs Cunningham: I commend you for the fact that you're talking about the inclusion of services to children. We're really looking for as much choice as we can get, and when we start looking at those kinds of numbers—I'm only speaking on behalf of my own experiences, of course, and certainly others who have come before the committee.

With regard to my second question and how you would be considering the appropriate agency to be designated, do you support the legislation's bias specifically against the boards of health?

Ms Fisher: I think the comment that we made refers to the fact that we're glad that it's been left open to more than municipalities and boards of health. We've barely begun the planning process in terms of the multiservice agencies, and I think the way we're going is more initially looking at the parameters of what would be included within that multiservice agency before we get into looking at models, and we are struggling with that, so looking at the different components being the access and the service delivery, management and governance and looking at what we presently have and then how that can be changed and then what kind of a process in terms of proposals.

Mrs Cunningham: So when we looked at—I think it was an appendix to the board of health's brief today, there was a presentation to the Thames Valley District Health Council. Therefore, we should assume that that's not a bias. You're just saying that you're pleased that the legislation has pointed out that there are agencies beyond the boards of health?

Ms Fisher: Paul, did you want to comment on that?

Mr Paul Huras: We haven't encouraged anyone to submit proposals, but proposals have been developed, and I think that's very appropriate for organizations to be looking at their future from a strategic approach. Some of them have decided that MSAs do fit with their mission and have developed proposals. We are accepting those proposals as information to help us in our determination of models and are advising people who do take it upon themselves to submit proposals, but we are not requesting proposals at this time. They may be very helpful to us in developing the type of model that would be appropriate for our community.

Ms Bamford: Just to add to Paul's comment, what we believe is that local communities should be doing planning with the assistance of the health council. So what we've done is we've established within each county a planning body, a long-term care committee, and each of those community planning bodies has subcommittees. It's a mass of volunteers, but that's how you ensure you get consumers, people. They don't have to go to London to plan for this. They can get help by their neighbours to go to the local church to meet to discuss how this long-term care system should look.

As Paul said, we're trying not to elicit proposals. This is not a competition; this is a collaboration. We're taking a community development approach. We're trying to get people working with each other to solve some of their own problems and to come to us with some solutions and some options as opposed to us saying: "This is the way

it's got to be. This is the way that we're going to solve your problems." And we think it's working. It's very painful, it's very time-consuming, but I think it's worthwhile.

Mrs Cunningham: Mr Chairman, could I ask a supplementary to that?

The Chair: I'm afraid we are a little tight on time and perhaps you can ask that separately.

Mrs Cunningham: I think just that probably the concern here is that if the governance of the board of health can be changed, they would be considered, but I'm not even sure why they should have to do that. That's my point.

Why would we get into this? Aren't we looking for an agency that can represent the needs of all of these clients they serve and administer these services? Isn't that what we're looking at? They may differ across the province and I guess I object to the boards of health being in there.

Ms Bamford: We're looking at collaboration, and we're expecting not various proposals competing from one part; we're looking for people to come together and reach some consensus. So the board of health will be very much a part of that planning, I think, just as much as the hospitals should have input as well. But I think the comment made by the long-term care committee reflects that there are community agencies out there who have already a lot of expertise in providing this type of service, and I'll use home care as an example. We need to build on that. We need to build on what they already know rather than try to invent some new structure.

The Chair: Thank you all for coming for the two presentations.

LYNNE HAMMOND

DORIS ADAMS

SUSAN DEFFETT

DONNA JORDAN

The Chair: If I could then call on the Oxford, Middlesex, London, Elgin, St Thomas home care case managers. That's a large area to be covered. Members have a copy of the presentation. Welcome to the committee. We appreciate you coming this afternoon and if you'd be good enough to introduce yourselves and then please go ahead with your presentation.

Mrs Lynne Hammond: Thank you. I'm Lynne Hammond from Middlesex county. On my right is Susan Deffett from Elgin county and on my left is Doris Adams from Oxford county, and doing our graphics for us this afternoon will be Donna Jordan from Middlesex.

The case managers of Middlesex, Oxford and Elgin counties thank you for this opportunity to address the committee in response to Bill 173. In reviewing section 20 of the bill and watching the Toronto hearings, it has become apparent to us that the role of the case manager is not well understood. Bill 173 does not directly address the case manager. Therefore, to clarify our role, we wish to present the paper which was previously given to our local district health council.

Case management is one of the best-kept secrets of

home care and is invisible to most people because of the nature of its role. Someone once said, "The art is concealing the art." We believe this applies to case management. Although case management is not always visible, it is a direct service as well as an integral part of the health care system, and will continue to be so.

We have chosen to compare a case manager's role with a client to a general contractor's role in building a house. They both work behind the scenes. Today, we will show you some examples of how a home care case manager builds a house. Later, we will show you a case manager of the future to build the house.

First, a brief background of case management. It has its roots in public health nursing and social work. It is considered to have begun in North America in 1863 when the Massachusetts Board of Charities established a case management program to coordinate public service and conserve public funds.

In southwestern Ontario, case management began in the mid-1960s as a pilot project when hospital liaisons started to plan services for patients discharged earlier than usual from hospitals. As home care expanded, the liaison title changed to coordinator and then to case manager, which reflected the increased responsibility of the position. Besides assessing clients for eligibility, case managers were to assist ineligible clients in finding alternate services. The role has continued to be refined because of changes in health care, yet its primary purpose remains the same as it was at its inception: to ensure that client needs are met in the most cost-effective manner.

To quote Kathy Desai, director of Oxford county home care and University of Western Ontario case management course instructor, "Whenever we as a society have wanted to balance quality and quantity, we have resurrected the case management model—hence its popularity today."

Again, the case manager of home care has many functions analogous to those of a general contractor. The general contractor, in building a house, knows who can get which job done for the best price in the most timely manner, so that his customer is satisfied. The case manager, by assessing, planning, coordinating and implementing, builds a house that meets the health needs of a client. The case manager also knows who can get which job done for the best price in a timely manner.

1720

The case manager builds a foundation with an assessment. The framework is then constructed with planning and coordinating of resources. The roof of the house ensures accountability.

We have chosen three vignettes requiring varying degrees of case management to demonstrate various aspects of our house-building.

Ms Doris Adams: Mrs W is a 72-year-old retired registered nurse who was widowed 10 years ago and has no other family. Although her eyesight has become progressively worse, on assessment, Mrs W related that the Canadian National Institute for the Blind had helped her to modify her kitchen. She was able to do her own meal preparation and laundry. She was also able to bathe independently. CNIB provided her with transportation to

their weekly functions and to the doctor. Mrs W had privately hired someone to do the vacuuming and the dusting. She was requesting that home care assist with occasional mending, reading her mail to her and transportation. The case manager explained the eligibility criteria for home care and that Mrs W currently was not eligible. The case manager recognized Mrs W's needs, however, and made a referral to Friendship in Action, as well as to a volunteer student group at the high school. The case manager contacted a senior citizens' group to check on more volunteer transportation for Mrs W. Her record will be kept on file for future reference at home care. The case manager is accountable to see that funds are used appropriately and that client needs are addressed.

Miss D is a 28-year-old woman who had a car accident which resulted in a fractured hip, crushed heel and fractured elbow. After a lengthy hospital stay, she went to her mother's home to convalesce. Physiotherapy and occupational therapy were requested by the doctor at the hospital and assessed as appropriate by the hospital case manager. However, once home, initial reports from the therapists indicated that both were addressing the same problems. After discussion, the case manager asked one therapist to discharge to prevent duplication.

By maintaining a flexible plan of care that is client-specific and preventing duplication, the case manager ensures that needs are met in a cost-effective manner.

Our final vignette: Mr B is a 45-year-old man who has supranuclear palsy, a progressive neurological disorder. The request for home care assessment was made by the doctor after the family had phoned him with the need for care giver relief. Mr B was assessed in his home by the case manager. Problems identified were complete loss of voice, difficulty eating and swallowing, loss of weight, increasing fatigue, deterioration in motor and cognitive functions and signs of depression.

It was quickly clear to the case manager that the client required a speech pathologist to develop some method of communication. A nutritionist was required to address his weight loss and nutritional needs. Some of the activities the client was trying to complete were difficult and tiring for him. The case manager saw a need for an occupational therapist to review safety issues and how the client was functioning in his activities of daily living.

The case manager planned to provide a nurse to teach basic nursing care to the care giver and provide emotional support. A homemaker was required to provide care giver relief, as the wife was tiring and the client could no longer be left alone safely. The case manager set up a tentative plan of care with the family at the time of assessment and began long-range planning. The need for family relief and future placement options were discussed. The wife and two daughters were visibly relieved that help would be available. The doctor was then contacted by the case manager and the needs were discussed. The doctor appreciated the direction for care of his patient and services were initiated.

Through the assessment process which had originated from a simple request for help, the case manager identified the client's extensive needs and established a plan to meet those needs and thus improve his quality of life.

Internal resources were identified as well, and the case manager worked to enable the client to utilize these effectively to promote independence. Maintaining independence in the community translates into decreased cost to the health care system and empowers the client and the family.

Ms Hammond: Our house, built with a foundation of assessment, a frame of planning and coordinating and a roof of accountability, ensures high-quality care delivered in a cost-effective manner with a human touch. The bricks covering our house are other skills and abilities of a case manager, including advocacy, flexibility, objectivity, listening skills, resourcefulness, interviewing skills, education, creativity and public relations.

We, as home care case managers, have reviewed our goals in line with directives given in the long-term care reform proposed. Who is better able to present a vision of case management reform within the proposed MSAs than the case managers? We have shown you our present houselike structure. The general contractor of the future will have a new approach to house-building because of changes in the economy and consumer demands for quality, and so must case managers. The house of the future shows our focus is now broader. This is demonstrated by changes in how the house will be built. For example, accountability joins assessment to form the foundation of the new house. A firm foundation of accountability in the new house provides the basis for building an innovative, flexible model of health services.

The case manager has always been accountable, yet the emphasis on it will be even greater in the future. With responsibility for assessments being shared with other professionals and the projected need for cost containment, accountability will need more emphasis. We place it, along with assessment, as part of the foundation of our new house. Case management of the future will continue to provide expertise and available resources, budget management and objectivity to other professionals involved with the clients.

We envision various levels of case management. Professor Carol Austin, a leading authority on case management, has described two levels of case management she terms "deep-dish" and "drive-by." Our example of drive-by style may be a client with a single professional service need to reduce duplication of assessments. The deep-dish style is for the vulnerable client, or the client with complex needs, such as the gentleman in our last vignette. Case management is a direct service to the deep-dish client, just as the nurse or therapist provides a direct service. The case manager would determine the appropriate level of case management for a given client.

Continuing with the construction, partnerships will replace and thus enhance coordination and planning as the framework of the house. The partnerships will be with clients and providers, to facilitate coordination and planning. Partnerships include shared responsibility and duties delegated to those who can achieve them in the most cost-effective manner. Partnerships focus on enabling and empowering clients in their decision-making and, ultimately, their own case management in some instances.

A partnership approach lends itself to a model that is flexible, creative and innovative.

We have chosen quality as the roof for the new house. We envision case managers assuming a larger role in quality assurance. The roof of quality will be made up of an interagency quality management program spanning traditional boundaries and improving quality on a continuous basis. A continuous quality program will not succeed without incorporating the values and wants of the consumers of care. The case manager alone will not be able to attain quality in home health care.

1730

University of Western Ontario researcher Dr Carol McWilliam describes a collaborative model, equally involving all agencies and all categories of participants, which will hold the only hope of implementing continuous quality improvement of in-home care. The case manager will contribute equally with all other partners in home health care to achieve the desired quality: an innovative, empowering, collaborative, continuous quality improvement partnership model.

The same bricks from our original model will be needed to construct our house of the future. The same skills and abilities will be required of the case manager of the future. We believe that by basing our foundation in accountability and assessment and by building on the foundation in partnerships, we can enhance the quality of life for residents of Middlesex, Oxford and Elgin counties. We therefore have put on a roof of quality.

Ruth Grier states: "Effectiveness means finding the treatment or program that produces the healthiest outcome. The quality of care we receive must be maintained at the high levels we expect and deserve." The district health council is the architect of our local MSAs. We leave you with our vision of the future.

Ms Susan Deffett: In summary, Bill 173 does not address case management. We believe that providing an independent case manager rather than assigning this role to one of the service providers will yield better and more cost-effective care in most cases. An objective, holistic assessment by a professional knowledgeable in community resources is essential. Expertise in assessment and resource management are distinctive qualities of present case managers.

Page 6 of the compendium, which addresses one-stop access through multiservice agencies, refers to a person who will take responsibility for providing accurate information, making appropriate referrals, assisting to identify needs assessment and determining eligibility, developing a plan of service with the consumer, arranging for workers to provide services, and monitoring and making necessary adjustments. We recommend this person be a professional case manager.

The Chair: Thank you very much for an innovative presentation. Ms Haslam.

Mrs Haslam: As a teacher, I appreciate the visual aids. It helps those of us—

The Chair: Especially at this point in the afternoon.

Mrs Haslam: Especially at 5:30 in the afternoon.

Thank you for your presentation. It certainly presents

your case very well. It's interesting that you mentioned Kathy Desai, because earlier she had made a presentation. She talks about integration, allowing case managers to do the job with the consumer, which is where I'm coming from, to be sure the consumer has as much input and control and involvement in it as possible, but also looking at the efficiency and cost-effectiveness of the program. She mentions that integration is the key to the success. I wondered if you could elaborate on that a little bit, versus a brokerage system.

Ms Hammond: Unfortunately, I wasn't here for Kathy's address.

Ms Donna Jordan: I think when we talk about the two different levels of case management, it suggests some flexibility there. I think that's what Kathy is maybe thinking there with integrating the home care in a better way, that you don't always need as much case management in some cases; you're integrating by allowing the nurse or the therapist to oversee some simple cases rather than allowing a professional case manager to do the case management.

Mrs Haslam: So it's that seamless system that we are very interested in going to rather than having three different people follow through. Okay.

The Chair: Thank you very much. The other thought that occurred, where I think you've done some subliminal work on case managers, is that most of us think of "deep dish" in relation to pizza. We'll never be able to order another deep-dish pizza without saying "case manager," so it'll keep you in the forefront. Thank you very much for coming and for the joint presentation.

CANADIAN RED CROSS SOCIETY

The Chair: I call the Canadian Red Cross Society, southwest region and Windsor branch. Welcome to the committee; it's nice to see you. I know you've been here listening to many of the other presentations. We're glad to have you with us. Please introduce yourselves and go ahead.

Ms Mary Kay Croft: If I had known, I'd have brought visual aids, but I have to tell you straight up we don't have any. My name is Mary Kay Croft and I'm regional director with the Red Cross homemaker service in southwestern Ontario. With me today are Walter Willms, who is the president of the branch council in Windsor for Red Cross, and Jim MacPherson, who is the regional director in southwestern Ontario.

On behalf of the Red Cross, I extend appreciation for the opportunity to share our thoughts and ideas around Bill 173. It is our intent to provide a brief summary of the report for you, and hopefully there will be time for questions and discussion. To do that, I'm going to talk fast.

The Canadian Red Cross Society is a non-profit charitable corporation incorporated under federal law. Canadian Red Cross Society, Ontario Division, is part of a worldwide family who on a daily basis offer humanitarian service to vulnerable population groups. Our international relief efforts in countries like Rwanda make the difference between life and death for people caught in horrific circumstances.

We are equally proud of our local efforts to provide help when help is needed. The Canadian Red Cross Society, Ontario Division, operates 78 branches across Ontario, offering services such as disaster relief and emergency training, blood collection and distribution, water safety and learn-to-swim programs, first aid and CPR training, and education in international humanitarian law and the terms of the Geneva conventions. In addition, almost all of our 78 branches, 10 of which are in the southwest region, run community-based long-term care programs such as homemaking, transportation and meal programs, home health care equipment loans, home maintenance, security checks and friendly visiting. The services are provided through the efforts of over 10,000 volunteers and 6,000 staff. The majority of those 6,000 staff are trained homemakers.

The corporate culture of the society is based on seven fundamental principles, including humanity, impartiality and voluntary service. As an international moral force in the world and the founder of the first homemaker service in Ontario, we can easily lend our support to a client bill of rights.

We support the concept of aging in place with accessible, responsive, quality-driven, coordinated, cost-efficient services that promote independence and choice and avoid inappropriate institutionalization.

Notwithstanding these areas of agreement, there are areas of Bill 173 that cause the Red Cross concern. Generally, we find the draft legislation is too prescriptive. It attempts to build a complete long-term care structure rather than a solid foundation upon which long-term care can evolve and grow. The legislation must recognize that the demands on the long-term care system and the services it provides will evolve and will change.

As currently drafted, the legislation prevents the Red Cross from becoming an MSA or even providing services as part of an MSA. The current community system has many strengths which the legislation could and must build on. Experienced community-based organizations such as Red Cross, with local boards, a proven track record and highly motivated staff and volunteers, are one of these strengths. It is unbelievable that the government would intentionally establish a system that ties our hands.

The recently announced memorandum of agreement between Red Cross, VON and Home Care in Windsor is a perfect example of building on existing resources to enhance service delivery. The agreement outlines a collaborative relationship that will attempt to achieve a number of the initiatives of long-term care reform, including improved access and better-coordinated service. An executive summary of this cooperative endeavour is at the back of your package.

1740

The government's push to implement draft legislation is confusing and frustrating at the local level. People are looking at this legislation and even in a draft form are trying to make it work. And as much as we'd like to say we have cooperation in communities, we have competition right now. Organizations are deking it out and people are still needing service while we're at the table deking it out. It's a waste of time and energy.

The wording of the legislation significantly devalues the role of the homemaker and may lead to a reversal of the growing appreciation of the homemaker as part of the health care team. The society has historically recognized how valued the front-line worker is to the client. We have put supervision, education and risk management processes in place to support homemakers and volunteers in the difficult job they do out in the community.

Our brief recommends three specific sections of the draft legislation that require amendments in our opinion. All would enhance the delivery of long-term care, specifically in part II, which deals with the categorization of community services.

Patterns of care are evolving rapidly. So are the scope and professional standards of each profession. In the future, new and different services will be required. There is no provision for this evolution in the draft legislation. In addition, the somewhat arbitrary division between homemaking and personal support services does not reflect today's reality or emerging trends.

Our recommendation is that the legislation be reworded to eliminate the specific references and categorization of community services, that the regulations to the act be used to define those services provided by an MSA, and that the act and the regulations respect the interrelationships of the professions and the work that the individuals are doing.

Part VI, section 13 sets limits on the MSA, this 80% you've been hearing about. All of us, I guess, are at you about that. Certainly our recommendation around that is that the legislation be reworded to remove the limits on the amount of service an MSA can purchase, and that the legislation enable each community to choose the best service delivery model and optimum mix of provider agencies to meet the needs in the community.

Our third recommendation deals with part VI, section 15, the section that requires the MSA to comply in four years with the provisions of the legislation. We recommend that this four-year time frame be eliminated.

I'm the lead act, so to say, and Mr Willms is going to offer some further comments.

Mr Walter Willms: Thank you, Mr Beer, members of the committee. It's indeed a pleasure to be before you again after six years of retirement, and it is doubly a pleasure to be here to represent the Canadian Red Cross Society, which is the world's greatest humanitarian organization.

I am delighted that I've been asked to be a spokesperson to comment on the Red Cross position as it pertains to Bill 173. I have had an association with the Red Cross for more than 50 years, as a student, a teacher and a blood donor. For nearly six years now I've had volunteer involvement in planning, policy-making, operations and management at branch, region and division levels for the Red Cross. Currently, I am the president of the local branch.

I want to reinforce the position of the Red Cross that has been articulated by Mary Kay Croft and add to it some of my personal comments at a ground, grassroots level, because I believe I've had some involvement in the

community which permits me to do so. First, what in my opinion may be some consequences or implications if the above concerns—categorization of community services, limitation on the amount of service that an MSA may purchase, full compliance with all aspects of the act within four years, and the rigid criteria or prerequisites for the identification and designation of MSAs—are not properly addressed or resolved?

First, in my opinion, valuable community resources—human resources, a multitude of experiences, existing infrastructures—will be lost. Undue efforts and energies will be directed to structure and organization rather than applied to delivery of services and the implementation of programs. Viable local options will not be exercised. A whole new wheel will be built or invented rather than existing wheels greased and their individual cogs meshed. Administrative details for implementation, delivery, recordkeeping and funding will become monstrous. Another level of governing bureaucracy will be created to oversee existing viable bodies whose roles will be dramatically reduced or altered or, worse yet, take over such bodies whose demise we may experience.

My personal background or experiences cause me to make some further comments at a layman's level. I am or have been a primary care giver for a mother, now age 88, and a mother-in-law, now age 83, each living independently with appropriate support systems; a wife who is a severe asthmatic; and a son who was a severe diabetic, lost his total eyesight at age 30 and died of a heart condition six years later.

In fulfilling my care giver responsibilities, I have had involvement with several community programs and services: VON, Home Care, Homemakers, Meals on Wheels, telephone assurance, security checks, transportation, home maintenance, and social and physical services of the CNIB—orientation, mobility, grooming and household safety. I am or have been involved with several community agencies in addition to my involvement with the Red Cross, namely:

(1) At a senior citizens' centres association I am a planner, a policymaker, a resource for staff and a provider of transportation services.

(2) I am involved with the Rotary Club, particularly with the adult assistance committee.

(3) I have been involved with the CNIB, the council on aging, children's rehabilitation centre and citizen advocacy.

(4) I have been very involved with the United Way for more than 30 years.

Thus, I believe I can make some personal comments with respect to the Red Cross position and the content of Bill 173.

People's needs and our appropriate responses to those needs do not fit into neat categories. The whole person must be treated. Coordinated, not categorized, services are required. The type of service, the intensity of the service and the priority of service can and do vary and fluctuate frequently. I know that from my experience with my mother.

The local, autonomous requirements for the designation

of MSAs preclude the use of existing infrastructures such as the Red Cross. I might also name the CNIB, the Canadian Cancer Society and others. Such provincial or national bodies will not collapse or disappear; they will find new niches. The proposed designation of MSAs may well force the demise of local organizations that have developed effective responses to local needs and priorities. Their loyal and committed followers, supporters and volunteers may not readily and quickly adjust to a new bureaucracy which for sheer size may be perceived as remote and faceless.

The limitation by category on the amount of service that may be purchased will prevent MSAs from purchasing from existing stable structures which have a proven track record in the delivery of community services.

1750

Legislation must provide for an umbrella or a coordinating structure which will stimulate a sharing among organizations that are incorporated provincially or nationally. Legislation must promote, for a merger or a cohesiveness, a coordination of local autonomous groups, local groups that have local charters and incorporations.

The 20% limitation on services that may be purchased, in my opinion, should not be applied to services that may be purchased at the local level from well-established not-for-profit organizations.

With today's technology, personal assessments, access to a multitude of services, recordkeeping and scheduling of services can and must be centrally coordinated. We have heard about the idea of one-stop shopping.

The actual delivery of services may well be handled by various agencies and structures which already have the infrastructure necessary to do so.

The user, the person for whom we want to provide in order that he or she may be spared from being institutionalized, cannot and does not want to deal with many contact points. If I wish to bring my mother, when she is able, to our home or to one of my siblings' homes for a couple of days, she or I must make at least five phone calls: VON, homemaker, Meals on Wheels, telephone assurance and security checks.

The system must respond to little things which are important for the whole person and which, unfortunately, easily slip through the cracks in a system that is rigidly categorized. This past winter, with its prolonged cold spells, seniors for whom I provided transportation for medical appointments and other legitimate needs were frustrated because they hadn't been able to walk to the corner to mail letters or cards, a very important part of living for them.

Albeit social and recreational services are identified in the proposed legislation as community support services, there has been, in my opinion, very little evidence in local planning communications to suggest that important wellness initiatives endeavours will be appropriately recognized. I think the legislation could be strengthened in this regard.

Finally, as already has been said, earlier this week representatives of the local VON, the Red Cross homemakers and the home care program proudly announced

the signing of a memorandum of agreement which forms a basis of a cooperative operating agreement designed to enhance service delivery of applicable services within our local community. Legislation must promote, legislation must enable more such agreements to be negotiated. Bill 173, as it is currently written, will be restrictive in those matters which we have identified and briefly elaborated on today.

I believe we must seek coordination, unification and cooperation and then develop the structure, rather than identify and designate a structure and thus force other bodies to succumb or to disappear.

Thank you for listening to us. We shall respond to questions that you may have.

The Chair: Thank you very much for the submission and for the copy of the memorandum of agreement, which is quite interesting, as well as, I just note for the record, the statement on the Canadian Red Cross and the positions that it's set out. We'll move to questions.

Mrs O'Neill: Thank you very much for coming. You're likely aware that you're not the first Red Cross that's come before us. I think the people in the north are really in desperate positions because I think there is a minimum of 25 communities that have no alternative but the Red Cross. These communities know that they are not going to have the same service under the same governance structures, with maybe not the same people, with an MSA. I think that is almost criminal; it's certainly incredible.

I find it very difficult that we would be dismantling the service of an organization such as yours and building something else in the service of home care, because your reputation precedes you, as I said.

I wonder if there is something you could tell us—I presume you're talking about a federated system, now that you've signed this memorandum of agreement. Could you tell us a little bit about that, how it came to be and what are some of the key features? Hopefully, that will be part of an MSA.

Ms Croft: Hopefully it works, if we can accomplish the principles, whatever you call it, it's working, it's meeting the principles and the goals. The name doesn't really matter.

The way it came about was rather interesting. A lot of talking preceded it, and sounding out and identifying needs. What it amounted to was that we saw some opportunities. We placed a Red Cross supervisor in the home care office for a period of three months. Home care in Windsor is administered by the VON. We have home care, VON and Red Cross all in the same office now, which is really remarkable, for those who are familiar with the system and with the purchase-of-service mentality that has gone on historically. "I'm paying you. You do what you're told and if you don't like it, I'm going to go to somebody else. Don't complain and don't manage the case. Just do what you're told."

This concept was really good, that we'd all get together and hunker down for three months. During that three-month period, all of us identified areas where there are opportunities to become more efficient in terms of

how we take information in, how we give information out, how we record it. It's the right hand talking to the left hand. Recognizing that, we then wanted to formalize our agreement and state our intentions right up front to the community, to the workers in our organization, to the volunteers. Within the agreement the roles of the three agencies are clearly identified. VON has agreed it's not going to do homemaking service. Red Cross has agreed we're not going to be doing nursing. In some communities, we're deking it out. We're saying: "I'm going to do it." "No, you're going to do it." "No, I'm going to do it." We said: "Look, VON, you're great. You're great at doing nursing. We're great at doing homemaking. Let's do what we're good at. Home care, you're good at case management. Do what you're good at and let's all do it together."

The memorandum very clearly outlines the roles of each. It establishes a volunteer advisory committee. It will be made up of some of us service providers who are involved, volunteers from the community and one other individual at this point; the district health council has asked to have a representative on that advisory council. That's the stage. The stage is set. We've identified our objectives, which are very much taken out of the long-term care document. You've set the stage, you've set the principles, you've made us look at it. Some of the goals that we've set are to look at our information systems, our communications systems, our intake process.

Mrs O'Neill: Are you, this body—I don't know what you're calling it—part of the scheme of the district health council's long-term planning committee? Are they looking at this as a possible MSA foundation? Where do you fit into the planning?

Ms Croft: I might ask Walter to comment on that. We did meet with the district health council before making the announcement. I will tell you that the three organizations pretty much had the concept nailed down when we went to the DHC, but the DHC did offer us comments.

Mr Willms: Further to that, I might add that there was discussion, that members of the Red Cross and members of the VON have served on various community committees under the jurisdiction of the district health council, so there has been liaison and involvement.

In addition to what Mary Kay Croft has said, I do want to emphasize that the agreement is at the operational level. There is absolutely no forfeiting, there is absolutely no waiving of any policy decision-making on the part of either body. I think in your question, Mrs O'Neill, you were asking something like, could this evolve into an MSA? My interpretation and understanding of Bill 173 is that it cannot because there is no way that the Red Cross will forfeit or waive its national and international status. Even though we have this agreement, it cannot be the beginning of an MSA under the legislation as it is currently worded. Therefore, we would propose coordinated efforts working under advisory boards. Integrated efforts would be established in order to use those infrastructures that we already have. It may be a federated model.

1800

Mrs O'Neill: Do you feel that the people you serve,

your clients, realize the service of the Red Cross is in jeopardy? Do you think that's well known?

Mr Willms: It's not well known, and let me say very quickly to you that the clients and consumers don't care as long as they get quality service. They have no interest in fact that you and I are sitting around the table debating and discussing and analysing structural possibilities.

Mrs O'Neill: So there's no affinity to the Red Cross as such.

Mr Willms: The affinity is to the quality of service.

Ms Croft: I agree with Walter. The most important thing is that the service is delivered. Secondly, people look at who's got what emblem and what's on, the name. The affinity that we see in our organization is with volunteers, such as Walter, who come into the organization and become our heart and conscience. For people like that in the community, the link with the organization is important.

I think over the long haul the client won't be able to say, "Oh gee, I wish Red Cross was here again," but what they're going to say is: "Oh my God, how did I get stuck in this bureaucracy, how did I get stuck where my worker isn't educated, supervised or supported in the field?" Because they're out there. "How did this happen?" They won't be able to say, "It's because Red Cross isn't here any more." They'll just know they're not going to be happy with it.

The Chair: Thank you all very much for coming before the committee this afternoon. We appreciate it.

PERSONS UNITED FOR SELF-HELP
WINDSOR AND ESSEX COUNTY

The Chair: We call our final witness for these hearings, Joan Cowie, who is the president of Persons United for Self-Help in Windsor-Essex. Ms Cowie, welcome to the committee. If I recall, you were also before us the last time that we were wandering the province, with Bill 101. We very much enjoyed your presentation at that time. I think it's perhaps fitting that we end our hearings here with you and the organization that you are with, because I know from experience the work that you do in the Windsor-Essex area. We're glad to have you even if it is at the end of a long day.

Ms Joan Cowie: I'll be real fast.

The Chair: That's quite all right. You take your time and tell us what you need to tell us.

Ms Cowie: I'd like to thank you very much for allowing me to be here. You'll have to excuse me, I've got a really sore throat. I think I had that on Bill 101 too.

The Chair: Maybe it's something about meeting with us.

Ms Cowie: I don't know.

I'd like to thank the committee for the opportunity. Unfortunately, we didn't find out until 10 to 5 on Friday afternoon that we were coming up, so I haven't had it all typed. I met with consumers Monday and Tuesday, getting bits and pieces together quickly and putting it all together last night at 2:30 in the morning. I hope that you can understand and appreciate how fast this has been done. I'll be real fast.

The Chair: That's fine.

Ms Cowie: My name is Joan Cowie. For those of you who don't know me, I am here representing PUSH—Windsor and Essex County. PUSH is a province-wide group that advocates and lobbies for the rights of persons with disabilities. We encourage our membership to become empowered and in control, to lead a life more independently.

A little background on myself: I have been involved with long-term care issues for 19 years; I have been addressing them for seven. I am a single mother with two able-bodied children and I have a life-threatening disease. I am a member of the Attendant Care Action Coalition; the long-term care coalition; TRAP, the Tenant Rights Advocacy Project, which involves support service living units; as well as our local long-term care committee of the Essex County District Health Council.

What I would like to address today are the following issues on Bill 173: long-term care services, children's services and consumer direct funding.

We, members of PUSH—Windsor and Essex County, feel that Bill 173 promises more even and fair distribution of and access to services within individual MSA service areas. We have reservations and concerns that truly comprehensive service provision is not adequately addressed by the bill. In fact, reviewing specific sections of the act, we feel that it largely entrenches the current rate of service providers by allowing them to maintain the control over the nature of the service, the eligibility, the amount, the criteria.

Although the intention of this act is to protect the consumer's right to complete and unfettered long-term care services through a so-called consumer bill of rights and appeal process, none the less ultimate front-line control remains the domain of the service provider.

Despite protection afforded the consumer, and particularly in parts VII, VIII and IX of the act, many consumers will remain reluctant to question or file any complaints regarding shortcomings or outright abuses of any services provided through the long-term care.

Unlike a consumer direct-funding model, where a consumer has and in fact endorses or accepts the policies of a service provider, through these consumers' allocations of long-term care dollars Bill 173 perpetuates a framework which presupposes that existing and future service providers know what is best for their clients or consumers. While this is not a completely wrong-minded or incorrect assumption, it is unrealistic and deterministic.

When the minister addressed these issues at the Woodden conference on June 14, 1994, which I attended, she spoke eloquently of the need for employment and increased consumer responsibility and various aspects; for example, attendant service, homemaking service, respite care services. Indeed, she announced the implementation of the pilot project involving the participation of 80 to 100 disabled consumers.

Clearly many, if not most, of the consumers or their advocates would prefer direct access to services they require in order to maintain the greatest degree of autonomy. While it is not always feasible to offer complete

independence of selection of services, the MSA-based model essentially sets the compendium of services offered and will indeed select those specific agencies and service providers in the community which best fit the MSA governance body's vision.

Respite services are grossly undersupplied in this bill. With greater medical technologies premature babies are living longer lives, consumers with disabilities are living longer and overall our health is improving. Unfortunately, this leaves a terrible burden on family care givers as funding for respite care decreases. More and more parents of children with disabilities are taking on extra attendant care, extra nursing services for their children's needs. Now we have senior parents still assisting with these tasks with their adult children with disabilities. What do you have in the end? A family burnout.

Despite the issue of political correctness, the disabled community feels compelled to criticize the way the long-term care act is slanted more towards seniors, instead of persons with disabilities and children with disabilities, in terms of the funding envelope. The majority of the funding is slanted towards seniors. One example of this bias, our local health care, is the quick response program. Although this program will deal with treatment of a disabled adult, such knowledge is carefully concealed from consumers and not commonly known in the community. Clearly, the QR program was designed to service and meet the needs of seniors. Contrary to the beliefs of acute care hospitals, mechanisms are not always in place for post-release care for disabled adults.

We have many questions and comments for this committee. I'd like to read them.

What about service for families of a child who fits this bill? If a parent is hospitalized or an emergency arises and he or she cannot be there to assist, does the ministry lift its rate or dollar that is allotted and provide more service? Who decides how much more service one gets? What may seem to be logical to the minister can be extremely short to the consumer who lives with this issue day in and day out. Who will be responsible for the consumers? Who will be responsible to the consumers who fall through the cracks in the system and who continue to fall through the cracks in the system in this act?

1810

We would like to know more about the direct funding. The minister announced direct funding through a pilot project on June 14, but in Bill 173 the control is still in the hands of the service provider. Consumers and service providers must have a good working relationship to both be successful.

Eligibility: How does one determine this? By income? If so, do you take into consideration how much one pays to maintain that consumer at home?

Ministry must change guidelines. When RN services needs increase, do not increase the homemaking. Ministry must go by a consumer-needs base. What about waiting lists? For some, the list can seem like an eternity. What is the ministry's definition of "services shall be planned in a timely fashion"?

Consistency within long-term care has not been properly addressed. We the disabled community need a clear definition of services from cradle to grave. Think of all the family criteria and families who must encompass all the children and all the disabilities. We must have a choice.

When a consumer goes into a hospital, do you have to reapply for these services after you're discharged? Will the doctors understand that? They just discharge you and you've got to wait 24 hours before your services start up again.

What impact will this have on long-term care services? We would like to comment that people with developmental disabilities are not even addressed in this act. We would also like to comment on a direct quote from Ruth Grier from Woodedden. She said:

"It goes a long way towards achieving this government's goals to expand community-based services, services that promote independence, that are consumer-based and accountable to the community, and that respond to the needs of the individual...."

"You've told us time and time again that people with disabilities want to develop a self-managed model for attendant services that gives them greater control and choice — one that promotes individual responsibility and encourages full participation in community life — one that permits you the flexibility to design your services around your needs and lifestyles."

Please, as a committee, seriously consider that Bill 173 in its current form facilitates these objectives. Thank you for your time and your attention on these issues, because everyone at one point in their lives will soon require long-term care.

Mrs Cunningham: I think most of us get some pretty good direct recommendations from your organization, not only of course in the Windsor-Essex area—I can speak for London, and there are others. I would like to congratulate you for being involved with PUSH because some of the practical things are missing some days when we're trying to change things for the better. I guess that's why we've got the hearings.

I made notes of what you stated and the appeal process is of concern, a tremendous concern. Also the fact that you're concerned about fair access to programs, long-term care type programs for children, certainly has been raised on more than one occasion today. The fact that you introduced the respite services, so important—

Ms Cowie: Yes, my mother's very tired.

Mrs Cunningham: Yes, I was thinking the same thing, this thing about burnout some of us relate to, waiting lists being a criterion and what not. I think from what you've stated—I'm going to ask you a question—is it fair to say that one of your greatest concerns is this direct care funding model, the one where you get to pick, and that there shouldn't be a cap on this 20%, so you can choose who you need to provide the services that you want?

Ms Cowie: Yes, it's very frustrating to sit back and know that consumer-direct funding has been effective immediately and there has been no direct funding given

out to anyone in the province. In my own life I'm a single parent of two small children. I have a total of 17 different attendant care people who come in and service me in a month. I have to say the Canadian Red Cross is very good with their homemakers; they keep them consistent. But you're trying to raise a family and you're trying to teach your children about strangers. How can you teach your children about strangers when there are so many different people coming into the home?

When you have respite come in, there are about seven or eight who do a weekend, 24 hours for three days, so there again, it's very frustrating as a disabled adult to sit there and say to your children, "Don't talk to this person, don't talk to this person." "But, Mommy, they were at our house last weekend." It's frustrating for the families, and what I think the government really needs to understand is that there is only one main care giver. So many times agencies come to us and say: "How many brothers do you have? How many sisters do you have? Your brother lives in the States. Could he come over for a weekend?" "No."

There's one main care giver and the main care givers are getting burnt out, they're getting older, and it makes you feel like a burden on them and it makes you feel very guilty.

Mrs Cunningham: Well, Joan—

Ms Cowie: The direct funding, yes, would make it a lot easier because you could hire in whoever you would like. You could have your attendant services and your homemaking services done all by the same person and you could maybe hire five to seven people, have five people and then two as a backup for vacations. That way it ensures continuity in the home and makes for a better relationship, not just between the attendant and the consumer, but within the whole family, because many times, agencies will say, "We don't have anything to do with the family."

Whatever person walks through the front door has to deal with every single member of the family, whether it's the parents, the children, the brothers, the sisters, the aunts, the uncles, grandparents, whoever. Consumer-direct funding would alleviate a lot of headaches for a lot of people with disabilities who are willing to manage their own services.

Mrs Cunningham: Thank you for telling your story. I sure relate because we have a care giver in our home for my 25-year-old son and, if I had to go to the extent that you have to go to, I don't think our family would have survived.

The first care giver we had stayed with us for four years and was a member of the family, and I thought was well paid. It would have cost me, if I had used the agencies, eight times the amount of a very fair salary for a very wonderful young man who got his degree at the University of Western Ontario at the same time as he helped us, with all of us helping out.

There are wonderful ways to make it happen, but I always said when I was at Merrymount, I could not have raised my children with the demands that were put on those single parents to, first of all, meet all the criteria so

that they could pick up the help that all of us have worked for to give them while they were raising their children.

1820

So I understand what you're saying. I think we get caught up in so much bureaucracy—

Ms Cowie: There was one meeting I came out of, a subcommittee meeting that I'm a chair of from the long-term care committee. I walked outside of this facility and I started to cry. It was because I'm caught in the bureaucracy of everything that's going on.

I just want my service. This is what want, this is how I want it done. I don't need this, this, this and this; I maybe just need this and this. It's very frustrating to get this across to the government. You come and you speak, and we've been speaking on this issue for so long, trying to get someone to listen to us. It's impossible.

Mrs Cunningham: There are a few of us that definitely relate, sitting around this table, because so many people are involved. Taking a look at the numbers that the Red Cross provided us with today, by the year 2010—what is it?—63% in some way will require these services. If we can't get it together, we're going to have a lot less productivity in our families and in our society. I think your children are the young people we're trying to influence.

Keep fighting, because you've made tremendous gains. We really respect the fact that you're here today and we are listening.

Ms Cowie: I don't want any child with a disability or their parents to have to go through what my parents did. I'm 25 and my mother sleeps over seven nights a week because we don't have respite care or the extra care that we need. I feel like a burden and I don't think that's fair to my mother. She is going to be in need of long-term services if this does not start moving and moving smart. Let's get it together. Let's not bicker at tables and about agencies. I'm tired of that. I want to get to work. Let's just have the service for the people and let's do it.

Mrs Cunningham: Has anything improved since the last time you came before a committee of the Legislative Assembly?

Ms Cowie: The last time I came to your committee I was still having the problem that my attendants will not serve—before, prior—they wouldn't serve my children the same meal as they will serve me. They still won't do that, the attendant care agency. They want a homemaker and at the same time—my seven-year-old has grown up a lot and I usually put his meal and my youngest son's meal on a plate and he carries it to the table. So, no, it's not making it any better.

I was given hope with the consumer-direct funding on June 14. I met Ruth Grier outside and I talked to her and I told her how important it was. They have to understand that there are people with disabilities whose children are growing up. They're getting married. They're having a job. They're going to school, having a job, having children, then their children are growing up. They need a little bit of assistance. They need that extra arm—

Mrs Cunningham: And some common sense.

Ms Cowie: Yes. But otherwise I'm still fighting.

Mrs Cunningham: Keep on.

The Chair: The parliamentary assistant wanted to respond to one of the points that you raised.

Mr Wessinger: It's certainly good to hear from you again. I know you'll be very interested in the direct funding pilot project that's going to commence this fall. I just wanted to make it clear on the record that the funding for that direct funding model is not part of Bill 173; it's funded under the Ministry of Community and Social Services Act.

The Chair: I want to thank you for coming before the committee. I recall the last time when you were before us and indeed remember the example which you just used. I think sometimes we have to be saying to ourselves, "Look, we've got to make progress and we've got to find ways to find solutions." I think we are all amazed, frankly, at the energy that you continue to show and we all wish you the very, very best. If you have to come before this committee again—

Ms Cowie: I hope I get invited.

The Chair: —we desperately hope that a lot of things will have happened and a lot of things for the good. So thank you very much.

Ms Cowie: Thank you very much for having me.

The Chair: Members of the committee—

Mrs Caplan: If I could interrupt just for one second, actually in an aside that I think Joan might be interested in, I asked Mr Quirt quietly when they thought the independent funding model might be in place and he said October.

Ms Cowie: But there's only 80 to 100. In that 80 to 100, how do you know if you're going to get chosen, and will it go all over Toronto? Will it come down to—

Mrs Caplan: All I can tell you is that—I was concerned in June that there was no time line—at least you'll have the answers to those questions by October.

Ms Cowie: Right.

Mr Quirt: The design of the direct funding pilot was assisted by folks from ACAC, the Attendant Care Action Coalition. They were involved with us in designing it. People from the independent living centres are helping us do the selection of those 80 to 100 people. Clearly it won't be all people from Toronto. I understand that there's a good representation of applications from the London area.

Ms Cowie: I hope it comes down to Windsor.

The Chair: Thank you very much for coming before the committee, and a safe trip home.

Ms Cowie: Thank you very much.

The Chair: Members of the committee, before we disperse, just two things: One, those of you who are taking the bus back to Toronto, it awaits you as I speak. So if you could get back to the hotel, it will be there, and pick up your bags. We now will be meeting again in Ottawa, beginning on September 12. While that may seem like many weeks away, I'm sure it will come quickly.

If I could, as a final word, just thank everyone—

Mr Wessenger: I think we have one left to do. We have some information to provide to committee members. We'll get it to the clerk and it can be distributed. This is in respect to the request for information that had been put in the previous occasions.

The Chair: Could I just ask for the record what that information is?

Mr Quirt: There are three things being distributed that were requested. One is a description of the former not-for-profit policy and the new requirements under the bill with respect to purchasing limits in the categories.

The second thing that was requested was a list of those

capital funding projects that had been approved for homes for the aged and other seniors programs for 1993-94 and 1994-95.

The third thing that's being provided that was requested is a comparison of the aspects of a service coordination model vis-à-vis an integrated model with respect to the objectives of the bill.

The Chair: Those members of the committee who aren't here at this time, we'll make sure they get copies of that.

With that, members of the committee, we stand adjourned until Monday, September 12, in Ottawa.

The committee adjourned at 1827.

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

***Chair / Président:** Beer, Charles (York-Mackenzie L)

***Vice-Chair / Vice-Président:** Eddy, Ron (Brant-Haldimand L)
Carter, Jenny (Peterborough ND)

***Cunningham, Dianne** (London North/-Nord PC)

Hope, Randy R. (Chatham-Kent ND)

Martin, Tony (Sault Ste Marie ND)

McGuinty, Dalton (Ottawa South/-Sud L)

O'Connor, Larry (Durham-York ND)

***O'Neill, Yvonne** (Ottawa-Rideau L)

Owens, Stephen (Scarborough Centre ND)

Rizzo, Tony (Oakwood ND)

***Wilson, Jim** (Simcoe West/-Ouest PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Abel, Donald (Wentworth North/-Nord ND) for Mr O'Connor

Caplan, Elinor (Oriole L) for Mr McGuinty

Haslam, Karen (Perth ND) for Ms Carter

Malkowski, Gary (York East/-Est ND) for Mr Hope

Sutherland, Kimble (Oxford ND) for Mr Rizzo

Wessinger, Paul (Simcoe Centre ND) for Mr Owens

Wininger, David (London South/-Sud ND) for Mr Martin

Also taking part / Autres participants et participantes:

Ministry of Health:

Czucar, Gail, legal counsel

Quirt, Geoff, acting executive director, long-term care division

Wessinger, Paul, parliamentary assistant to the minister

Clerk / Greffier: Arnott, Doug

Staff / Personnel: Boucher, Joanne, research officer, Legislative Research Service

CONTENTS

Thursday 25 August 1994

Long-Term Care Act, 1994, Bill 173, Mrs Grier / Loi de 1994 sur les soins de longue durée,	
projet de loi 173, <i>M^{ne} Grier</i>	S-1975
Reg Heasman	S-1975
Perth County Long-term Care Planning Committee	S-1977
Sandra Hanmer, chair	
The Lambton Alliance	S-1979
Joyce Anderson, chair	
Jim Larocque, chair, Lambton Senior's Association	
Do-R-Best Women's Institute	S-1981
Mona May Thompson, program coordinator	
Helen Havlik, member	
Port Franks Seniors Action Club	S-1983
Ken Reffell, member	
Kathy Desai	S-1985
Anne Fowler	S-1988
Victorian Order of Nurses, Southwest region	S-1990
Janice McCallum, president, Middlesex-Elgin branch	
Kathy Bamford, executive director, Oxford branch	
Catherine Goetz-Perry, executive director, Grey-Bruce branch	
Belle River and District Community Council	S-1996
Janet St Pierre, executive director	
Cheshire Homes of London Inc	S-1997
Mary-Anne Elie, board member	
Judi Fisher, executive director	
Participation House Support Services, London and area	S-1999
Elizabeth Leighton, board president	
City of Windsor social services department	S-2003
Dana Howe, commissioner of social services	
Mrs Peggy Davis, director, special services	
Independent Living Centre, London and area	S-2006
Steve Balcom, president	
Ontario Community Support Association, areas 1, 2 and 3	S-2009
Sue Hillis, director, area 2	
Heather Richardson, director, area 3	
Middlesex-London Health Unit	S-2012
Dr Graham Pollett, medical officer of health	
Kent County District Health Council	S-2015
Bruce McCallum, chair, long-term care steering committee	
Mary Lee, member	
Paul Balkwill, chair, multiservice agency committee and member, long-term care steering committee	
Persons United for Self-Help, southwestern region	S-2019
Myrtle Evans, vice-chair	
St Joseph's Health Centre, Sarnia; St Joseph's Health Centre, London	S-2021
Don McDermott, administrator, Sarnia centre	
Philip Hassen, president, London centre	
District Health Councils of Southwestern Ontario; Thames Valley District Health Council	S-2024
Kathryn Bamford, chair, Thames Valley DHC	
Judi Fisher, member, long-term care planning committee, Thames Valley DHC	
Paul Huras, executive director, Thames Valley DHC	
Lynne Hammond; Doris Adams; Susan Deffett; Donna Jordan	S-2027
Canadian Red Cross Society	S-2030
Mary Kay Croft, regional director, southwestern Ontario homemaker service	
Walter Wilms, council president, Windsor branch	
Persons United for Self-Help, Windsor and Essex county	S-2033
Joan Cowie, president	

JUL 5 1995

3 1761 11467188 6

